Filing at a Glance

Company:	Coordinated Care Corporation
Product Name:	Ambetter
State:	Indiana
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Form/Rate
Date Submitted:	05/09/2014
SERFF Tr Num:	CECO-129528781
SERFF Status:	Closed-Approved
State Tr Num:	35065IN001
State Status:	Closed
Co Tr Num:	35065IN001
Implementation Date Requested:	01/01/2015
Author(s):	Jonathan Szerszen, Susan Kohler, Tracey McMillan, Juan Guerra, Lisa Cerven, Daniel Martinez, Aurora Loaiza, Thomas Brophy, Michelle Fitzpatrick, Wendy Connally, Nickole Ellis
Reviewer(s):	Bobbi Henn (primary), Karl Knable
Disposition Date:	08/29/2014
Disposition Status:	Approved
Implementation Date:	01/01/2015

State Filing Description:
HMIN

State: *Indiana* **Filing Company:** *Coordinated Care Corporation*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Ambetter*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Michelle Fitzpatrick

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 08/29/2014
State Status Changed: 08/08/2014
Created By: Daniel Martinez
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Exchange Intentions: Exchange Only

Filing Description:
Re: Ambetter from Coordinated Care Corporation, dba MHS
NAIC No.: 95831
FEIN: 39-1821211

INDIVIDUAL HMO “EXCHANGE” MAJOR MEDICAL– FORM FILING
Form(s): Individual HMO Policy/Contract – 35065IN001, 35065IN002, 35065IN003
Schedule of Benefits – See attached Forms Schedule
Rates & Actuarial Memorandum

The attached forms are being submitted to your Department for review and approval. We are submitting the captioned product and plans offered from Coordinated Care, dba MHS, to be marketed and sold on the Marketplace in Indiana.

The rates are also part of this filing. The underlying projected claims costs and resulting premium were developed based on the data provided in the Spend Down Exchange Impact (provided by the state) and anticipated 2015 statewide enrollment in the individual market both on and off the exchange. However, based on communication from the IDOI, additional information on the spend-down population will be provided by the state that could provide information that significantly impacts the projected cost estimates or the effectiveness of medical management programs. As a result, we reserve the right to change our rates based on the information available in the next few weeks.

Please note that forms 35065IN001, 35065IN002, 35065IN003 and the schedules pertaining to plans 35065IN0010004, 35065IN0010002, 35065IN0010007, 35065IN0010008, 35065IN0010009, 35065IN0010012, 35065IN0010013, 35065IN0020002, 35065IN0020004, 35065IN0020007, 35065IN0020008, 35065IN0020009, 35065IN0020012, 35065IN0020013, 35065IN0030002, 35065IN0030004, 35065IN0030007, 35065IN0030008, 35065IN0030009, 35065IN0030012, and 35065IN0030013, were filed and approved last year under SERFF Filing No. CELT-128986928. We have made only minimal changes to these forms, including changing the plan names which is a uniform modification to all our policies pursuant to 45 CFR 148.122(g), Guaranteed Renewability of Individual Health Insurance Coverage. These changes are in compliance with both state and federal guidelines (45 CFR 148.122(g)), and the 2014 on-exchange filing is guaranteed renewable under the uniform modification criteria. We have included red-lined versions of the forms under the Supporting document tab to assist in your review. The existing plans noted above that we have elected to renew, do not have any changes with respect to cost share, nor have their benefits been altered.

Additionally, plans 35065IN0010001, 35065IN0010003, 35065IN0010006, 35065IN0010011, 35065IN0020001, 35065IN0020003, 35065IN0020006, 35065IN0020011, 35065IN0030001
35065IN0030003, 35065IN0030006, 35065IN0030011 were filed and approved by the Department under the SERFF tracking number referenced above, however, during the certification and agreement period with CMS, Coordinated Care elected to remove these plans from QHP certification. As a result, these plans were not certified as a QHP, and were not made available on the Marketplace. The plans noted above that were withdrawn from certification have not been submitted for review and approval.

For plan year 2015, we have filed for approval the following new plans:
35065IN0010014Ambetter Balanced Care 2
35065IN0010015Ambetter Balanced Care 1
35065IN0010016Ambetter Essential Care 2
35065IN0010017Ambetter Essential Care 2
35065IN0020014Ambetter Balanced Care 2 + Vision
35065IN0020015Ambetter Balanced Care 1 + Vision
35065IN0020016Ambetter Essential Care 2 + Vision
35065IN0020017Ambetter Essential Care 1 + Vision
35065IN0030014Ambetter Balanced Care 2 + Vision + Adult Dental
35065IN0030015Ambetter Balanced Care 1 + Vision + Adult Dental
35065IN0030016 Ambetter Essential Care 2 + Vision + Adult Dental
35065IN0030017 Ambetter Essential Care 1 + Vision + Adult Dental

Pursuant to proposed rule 45 CFR §148.122, we are discontinuing plans 35065IN0010005, 35065IN0010010, 35065IN0020005, 35065IN0020010, 35065IN0030005, and 35065IN0030010. We will provide notice to each individual provided coverage by these plans utilizing the draft letter issued by CMS ninety (90) days prior to discontinuance. Additionally, we will also formally file a notice of discontinuance of these plans via SERFF to the Indiana Department of Insurance.

If you have any questions, please feel free to contact me at the phone number listed below. Thank you for your consideration, we look forward to your favorable review.

Sincerely,

Michelle C. Fitzpatrick
Phone No. 312-332-8537

Attachments

Company and Contact

Filing Contact Information

Michelle Fitzpatrick, MichelleFitzpatrick@celtic-net.com
Sears Tower 312-332-8537 [Phone]
233 South Wacker Drive
Suite 700
Chicago, IL 60606

State: *Indiana* **Filing Company:** *Coordinated Care Corporation*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Ambetter*
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Filing Company Information

Coordinated Care Corporation
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204
(877) 647-4848 ext. [Phone]

CoCode: 95831
Group Code: 1295
Group Name: Centene Corp Grp
FEIN Number: 39-1821211

State of Domicile: Indiana
Company Type: Health Maintenance Organization
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,000.00
Retaliatory?	No
Fee Explanation:	Fees are capped at $1,000. We have over 100 form filings and one rate filing, therefore, the fee is $1,000.
Per Company:	Yes

Company	Amount	Date Processed	Transaction #
Coordinated Care Corporation	$1,000.00	05/09/2014	82103811

Check Number	Check Amount	Check Date
	$0.00	

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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		HMO Major Medical Policy	35065IN001	POL	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN001 Final.pdf
						Replaced Form Number:	*35065IN001*		
2		HMO Major Medical Policy	35065IN002	POL	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN002 Final.pdf
						Replaced Form Number:	*35065IN002*		
3		HMO Major Medical Policy	35065IN003	POL	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN003 Final.pdf
						Replaced Form Number:	*35065IN003*		
4		Ambetter Secure Care 2 Standard	35065IN001 0002-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010002-01.pdf
						Replaced Form Number:	*35065IN0010002 -01*		
5		Ambetter Secure Care 2 Zero Cost Share	35065IN001 0002-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010002-02.pdf
						Replaced Form Number:	*35065IN0010002 -02*		
6		Ambetter Secure Care 2 Limited Cost Sharing	35065IN001 0002-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010002-03.pdf
						Replaced Form Number:	*35065IN0010002 -03*		
7		Ambetter Secure Care 1 with 3 Free PCP Visits Standard	35065IN001 0004-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010004-01.pdf
						Replaced Form Number:	*35065IN0010004 -01*		
8		Ambetter Secure Care 1 with 3 Free PCP Visits Zero Cost Share	35065IN001 0004-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010004-02.pdf
						Replaced Form Number:	*35065IN0010004 -02*		
9		Ambetter Secure Care 1 with 3 Free PCP Visits Limited Cost Share	35065IN001 0004-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010004-03.pdf
						Replaced Form Number:	*35065IN0010004 -03*		

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Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
10		Ambetter Balanced Care 3 Standard	35065IN0010007-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010007-01.pdf
						Replaced Form Number:	*35065IN0010007-01*		
11		Ambetter Balanced Care 3 Zero Cost Share	35065IN0010007-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010007-02.pdf
						Replaced Form Number:	*35065IN0010007-02*		
12		Ambetter Balanced Care 3 Limited Cost Share	35065IN0010007-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010007-03.pdf
						Replaced Form Number:	*35065IN0010007-03*		
13		Ambetter Balanced Care 3 73% AV	35065IN0010007-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010007-04.pdf
						Replaced Form Number:	*35065IN0010007-04*		
14		Ambetter Balanced Care 3 87% AV	35065IN0010007-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010007-05.pdf
						Replaced Form Number:	*35065IN0010007-05*		
15		Ambetter Balanced Care 3 94% AV	35065IN0010007-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010007-06.pdf
						Replaced Form Number:	*35065IN0010007-06*		
16		Ambetter Balanced Care 4 Standard	35065IN0010008-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010008-01.pdf
						Replaced Form Number:	*35065IN0010008-01*		
17		Ambetter Balanced Care 4 Zero Cost Share	35065IN0010008-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010008-02.pdf
						Replaced Form Number:	*35065IN0010008-02*		
18		Ambetter Balanced Care 4 Limited Cost Share	35065IN0010008-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010008-03.pdf
						Replaced Form Number:	*35065IN0010008-03*		

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Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
19		Ambetter Balanced Care 4 73% AV	35065IN0010008-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010008-04.pdf
						Replaced Form Number:	*35065IN0010008-04*		
20		Ambetter Balanced Care 4 87% AV	35065IN0010008-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010008-05.pdf
						Replaced Form Number:	*35065IN0010008-05*		
21		Ambetter Balanced Care 4 94% AV	35065IN0010008-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010008-06.pdf
						Replaced Form Number:	*35065IN0010008-06*		
22		Ambetter Balanced Care 5 Standard	35065IN0010009-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010009-01.pdf
						Replaced Form Number:	*35065IN0010009-01*		
23		Ambetter Balanced Care 5 Zero Cost Share	35065IN0010009-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010009-02.pdf
						Replaced Form Number:	*35065IN0010009-02*		
24		Ambetter Balanced Care 5 Limited CS	35065IN0010009-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010009-03.pdf
						Replaced Form Number:	*35065IN0010009-03*		
25		Ambetter Balanced Care 5 73% AV	35065IN0010009-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010009-04.pdf
						Replaced Form Number:	*35065IN0010009-04*		
26		Ambetter Balanced Care 5 87% AV	35065IN0010009-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010009-05.pdf
						Replaced Form Number:	*35065IN0010009-05*		
27		Ambetter Balanced Care 5 94% AV	35065IN0010009-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010009-06.pdf
						Replaced Form Number:	*35065IN0010009-06*		
28		Ambetter Balanced Care 2 Standard	35065IN0010014-01	SCH	Initial				35065IN0010014-01.pdf

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Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
29		Ambetter Balanced Care 2 Zero Cost Share	35065IN0010014-02	SCH	Initial				35065IN0010014-02.pdf
30		Ambetter Balanced Care 2 Limited Cost Share	35065IN0010014-03	SCH	Initial				35065IN0010014-03.pdf
31		Ambetter Balanced Care 2 73% AV	35065IN0010014-04	SCH	Initial				35065IN0010014-04.pdf
32		Ambetter Balanced Care 2 87% AV	35065IN0010014-05	SCH	Initial				35065IN0010014-05.pdf
33		Ambetter Balanced Care 2 94% AV	35065IN0010014-06	SCH	Initial				35065IN0010014-06.pdf
34		Ambetter Balanced Care 1 Standard	35065IN0010015-01	SCH	Initial				35065IN0010015-01.pdf
35		Ambetter Balanced Care 1 Zero Cost Share	35065IN0010015-02	SCH	Initial				35065IN0010015-02.pdf
36		Ambetter Balanced Care 1 Limited Cost Share	35065IN0010015-03	SCH	Initial				35065IN0010015-03.pdf
37		Ambetter Balanced Care 1 73% AV	35065IN0010015-04	SCH	Initial				35065IN0010015-04.pdf
38		Ambetter Balanced Care 1 87% AV	35065IN0010015-05	SCH	Initial				35065IN0010015-05.pdf
39		Ambetter Balanced Care 1 94% AV	35065IN0010015-06	SCH	Initial				35065IN0010015-06.pdf
40		Ambetter Essential Care 3 with 3 Free PCP Visits Standard	35065IN0010012-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010012-01.pdf
						Replaced Form Number:	*35065IN0010012-01*		
41		Ambetter Essential Care 3 with 3 Free PCP Visits Zero CS	35065IN0010012-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010012-02.pdf
						Replaced Form Number:	*35065IN0010012-02*		
42		Ambetter Essential Care 3 with 3 Free PCP Visits Limited CS	35065IN0010012-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010012-03.pdf
						Replaced Form Number:	*35065IN0010012-03*		

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Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
43		Ambetter Essential Care 4 with 3 Free PCP Visits Standard	35065IN0010013-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010013-01.pdf
						Replaced Form Number:	*35065IN0010013-01*		
44		Ambetter Essential Care 4 with 3 Free PCP Visits Zero CS	35065IN0010013-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010013-02.pdf
						Replaced Form Number:	*35065IN0010013-02*		
45		Ambetter Essential Care 4 with 3 Free PCP Visits Limited CS	35065IN0010013-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0010013-03.pdf
						Replaced Form Number:	*35065IN0010013-03*		
46		Ambetter Essential Care 2 Standard	35065IN0010016-01	SCH	Initial				35065IN0010016-01.pdf
47		Ambetter Essential Care 2 Zero CS	35065IN0010016-02	SCH	Initial				35065IN0010016-02.pdf
48		Ambetter Essential Care 2 Limited CS	35065IN0010016-03	SCH	Initial				35065IN0010016-03.pdf
49		Ambetter Essential Care 1 Standard	35065IN0010017-01	SCH	Initial				35065IN0010017-01.pdf
50		Ambetter Essential Care 1 Zero CS	35065IN0010017-02	SCH	Initial				35065IN0010017-02.pdf
51		Ambetter Essential Care 1 Limited CS	35065IN0010017-03	SCH	Initial				35065IN0010017-03.pdf
52		Ambetter Secure Care 2 + Vision Standard	35065IN0020002-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020002-01.pdf
						Replaced Form Number:	*35065IN0020002-01*		
53		Ambetter Secure Care 2 + Vision Zero CS	35065IN0020002-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020002-02.pdf
						Replaced Form Number:	*35065IN0020002-02*		
54		Ambetter Secure Care 2 + Vision Limited CS	35065IN0020002-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020002-03.pdf
						Replaced Form Number:	*35065IN0020002-03*		

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Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
55		Ambetter Secure Care 1 with 3 Free PCP Visits + Vision Standard	35065IN0020004-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020004-01.pdf
						Replaced Form Number:	*35065IN0020004-01*		
56		Ambetter Secure Care 1 with 3 Free PCP Visits + Vision Zero CS	35065IN0020004-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020004-02.pdf
						Replaced Form Number:	*35065IN0020004-02*		
57		Ambetter Secure Care 1 with 3 Free PCP Visits + Vision Limited CS	35065IN0020004-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020004-03.pdf
						Replaced Form Number:	*35065IN0020004-03*		
58		Ambetter Balanced Care 3 + Vision Standard	35065IN0020007-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020007-01.pdf
						Replaced Form Number:	*35065IN0020007-01*		
59		Ambetter Balanced Care 3 + Vision Zero CS	35065IN0020007-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020007-02.pdf
						Replaced Form Number:	*35065IN0020007-02*		
60		Ambetter Balanced Care 3 + Vision Limited CS	35065IN0020007-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020007-03.pdf
						Replaced Form Number:	*35065IN0020007-03*		
61		Ambetter Balanced Care 3 + Vision 73% AV	35065IN0020007-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020007-04.pdf
						Replaced Form Number:	*35065IN0020007-04*		
62		Ambetter Balanced Care 3 + Vision 87% AV	35065IN0020007-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020007-05.pdf
						Replaced Form Number:	*35065IN0020007-05*		
63		Ambetter Balanced Care 3 + Vision 94% AV	35065IN0020007-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020007-06.pdf
						Replaced Form Number:	*35065IN0020007-06*		

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64		Ambetter Balanced Care 4 + Vision Standard	35065IN0020008-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020008-01.pdf
						Replaced Form Number:	*35065IN0020008-01*		
65		Ambetter Balanced Care 4 + Vision Zero CS	35065IN0020008-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020008-02.pdf
						Replaced Form Number:	*35065IN0020008-02*		
66		Ambetter Balanced Care 4 + Vision Limited CS	35065IN0020008-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020008-03.pdf
						Replaced Form Number:	*35065IN0020008-03*		
67		Ambetter Balanced Care 4 + Vision 73% AV	35065IN0020008-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020008-04.pdf
						Replaced Form Number:	*35065IN0020008-04*		
68		Ambetter Balanced Care 4 + Vision 87% AV	35065IN0020008-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020008-05.pdf
						Replaced Form Number:	*35065IN0020008-05*		
69		Ambetter Balanced Care 4 + Vision 94% AV	35065IN0020008-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020008-06.pdf
						Replaced Form Number:	*35065IN0020008-06*		
70		Ambetter Balanced Care 5 + Vision Standard	35065IN0020009-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020009-01.pdf
						Replaced Form Number:	*35065IN0020009-01*		
71		Ambetter Balanced Care 5 + Vision Zero CS	35065IN0020009-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020009-02.pdf
						Replaced Form Number:	*35065IN0020009-02*		
72		Ambetter Balanced Care 5 + Vision Limited CS	35065IN0020009-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020009-03.pdf
						Replaced Form Number:	*35065IN0020009-03*		

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73		Ambetter Balanced Care 5 + Vision 73% AV	35065IN0020009-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020009-04.pdf
						Replaced Form Number:	*35065IN0020009-04*		
74		Ambetter Balanced Care 5 + Vision 87% AV	35065IN0020009-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020009-05.pdf
						Replaced Form Number:	*35065IN0020009-05*		
75		Ambetter Balanced Care 5 + Vision 94% AV	35065IN0020009-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020009-06.pdf
						Replaced Form Number:	*35065IN0020009-06*		
76		Ambetter Balanced Care 2 + Vision Standard	35065IN0020014-01	SCH	Initial				35065IN0020014-01.pdf
77		Ambetter Balanced Care 2 + Vision Zero CS	35065IN0020014-02	SCH	Initial				35065IN0020014-02.pdf
78		Ambetter Balanced Care 2 + Vision Limited CS	35065IN0020014-03	SCH	Initial				35065IN0020014-03.pdf
79		Ambetter Balanced Care 2 + Vision 73% AV	35065IN0020014-04	SCH	Initial				35065IN0020014-04.pdf
80		Ambetter Balanced Care 2 + Vision 87% AV	35065IN0020014-05	SCH	Initial				35065IN0020014-05.pdf
81		Ambetter Balanced Care 2 + Vision 94% AV	35065IN0020014-06	SCH	Initial				35065IN0020014-06.pdf
82		Ambetter Balanced Care 1 + Vision Standard	35065IN0020015-01	SCH	Initial				35065IN0020015-01.pdf
83		Ambetter Balanced Care 1 + Vision Zero CS	35065IN0020015-02	SCH	Initial				35065IN0020015-02.pdf

State: Indiana **Filing Company:** Coordinated Care Corporation
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Product Name: Ambetter
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
84		Ambetter Balanced Care 1 + Vision Limited CS	35065IN0020015-03	SCH	Initial				35065IN0020015-03.pdf
85		Ambetter Balanced Care 1 + Vision 73% AV	35065IN0020015-04	SCH	Initial				35065IN0020015-04.pdf
86		Ambetter Balanced Care 1 + Vision 87% AV	35065IN0020015-05	SCH	Initial				35065IN0020015-05.pdf
87		Ambetter Balanced Care 1 + Vision 94% AV	35065IN0020015-06	SCH	Initial				35065IN0020015-06.pdf
88		Ambetter Essential Care 3 with 3 Free PCP Visits + Vision Standard	35065IN0020012-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020012-01.pdf
						Replaced Form Number:	*35065IN0020012-01*		
89		Ambetter Essential Care 3 with 3 Free PCP Visits + Vision Zero CS	35065IN0020012-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020012-02.pdf
						Replaced Form Number:	*35065IN0020012-02*		
90		Ambetter Essential Care 3 with 3 Free PCP Visits + Vision Limited CS	35065IN0020012-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020012-03.pdf
						Replaced Form Number:	*35065IN0020012-03*		
91		Ambetter Essential Care 4 with 3 Free PCP Visits + Vision Standard	35065IN0020013-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020013-01.pdf
						Replaced Form Number:	*35065IN0020013-01*		
92		Ambetter Essential Care 4 with 3 Free PCP Visits + Vision Zero CS	35065IN0020013-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020013-02.pdf
						Replaced Form Number:	*35065IN0020013-02*		
93		Ambetter Essential Care 4 with 3 Free PCP Visits + Vision Limited CS	35065IN0020013-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0020013-03.pdf
						Replaced Form Number:	*35065IN0020013-03*		

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94		Ambetter Essential Care 2 + Vision Standard	35065IN0020016-01	SCH	Initial				35065IN0020016-01.pdf
95		Ambetter Essential Care 2 + Vision Zero CS	35065IN0020016-02	SCH	Initial				35065IN0020016-02.pdf
96		Ambetter Essential Care 2 + Vision Limited CS	35065IN0020016-03	SCH	Initial				35065IN0020016-03.pdf
97		Ambetter Essential Care 1 + Vision Standard	35065IN0020017-01	SCH	Initial				35065IN0020017-01.pdf
98		Ambetter Essential Care 1 + Vision Zero CS	35065IN0020017-02	SCH	Initial				35065IN0020017-02.pdf
99		Ambetter Essential Care 1 + Vision Limited CS	35065IN0020017-03	SCH	Initial				35065IN0020017-03.pdf
100		Ambetter Secure Care 2 + Vision + Adult Dental Standard	35065IN0030002-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030002-01.pdf
						Replaced Form Number:	*35065IN0030002-01*		
101		Ambetter Secure Care 2 + Vision + Adult Dental Zero CS	35065IN0030002-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030002-02.pdf
						Replaced Form Number:	*35065IN0030002-02*		
102		Ambetter Secure Care 2 + Vision + Adult Dental Limited CS	35065IN0030002-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030002-03.pdf
						Replaced Form Number:	*35065IN0030002-03*		
103		Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental Standard	35065IN0030004-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030004-01.pdf
						Replaced Form Number:	*35065IN0030004-01*		

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104		Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental Zero CS	35065IN0030004-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030004-02.pdf
						Replaced Form Number:	*35065IN0030004-02*		
105		Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental Limited CS	35065IN0030004-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030004-03.pdf
						Replaced Form Number:	*35065IN0030004-03*		
106		Ambetter Balanced Care 3 + Vision + Adult Dental Standard	35065IN0030007-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030007-01.pdf
						Replaced Form Number:	*35065IN0030007-01*		
107		Ambetter Balanced Care 3 + Vision + Adult Dental Zero CS	35065IN0030007-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030007-02.pdf
						Replaced Form Number:	*35065IN0030007-02*		
108		Ambetter Balanced Care 3 + Vision + Adult Dental Limited CS	35065IN0030007-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030007-03.pdf
						Replaced Form Number:	*35065IN0030007-03*		
109		Ambetter Balanced Care 3 + Vision + Adult Dental 73% AV	35065IN0030007-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030007-04.pdf
						Replaced Form Number:	*35065IN0030007-04*		
110		Ambetter Balanced Care 3 + Vision + Adult Dental 87% AV	35065IN0030007-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030007-05.pdf
						Replaced Form Number:	*35065IN0030007-05*		
111		Ambetter Balanced Care 3 + Vision + Adult Dental 94% AV	35065IN0030007-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030007-06.pdf
						Replaced Form Number:	*35065IN0030007-06*		
112		Ambetter Balanced Care 4 + Vision + Adult Dental Standard	35065IN0030008-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030008-01.pdf
						Replaced Form Number:	*35065IN0030008-01*		

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Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
113		Ambetter Balanced Care 4 + Vision + Adult Dental Zero CS	35065IN0030008-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030008-02.pdf
						Replaced Form Number:	*35065IN0030008-02*		
114		Ambetter Balanced Care 4 + Vision + Adult Dental Limited CS	35065IN0030008-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030008-03.pdf
						Replaced Form Number:	*35065IN0030008-03*		
115		Ambetter Balanced Care 4 + Vision + Adult Dental 73% AV	35065IN0030008-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030008-04.pdf
						Replaced Form Number:	*35065IN0030008-04*		
116		Ambetter Balanced Care 4 + Vision + Adult Dental 87% AV	35065IN0030008-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030008-05.pdf
						Replaced Form Number:	*35065IN0030008-05*		
117		Ambetter Balanced Care 4 + Vision + Adult Dental 94% AV	35065IN0030008-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030008-06.pdf
						Replaced Form Number:	*35065IN0030008-06*		
118		Ambetter Balanced Care 5 + Vision + Adult Dental Standard	35065IN0030009-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030009-01.pdf
						Replaced Form Number:	*35065IN0030009-01*		
119		Ambetter Balanced Care 5 + Vision + Adult Dental Zero CS	35065IN0030009-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030009-02.pdf
						Replaced Form Number:	*35065IN0030009-02*		
120		Ambetter Balanced Care 5 + Vision + Adult Dental Limited CS	35065IN0030009-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030009-03.pdf
						Replaced Form Number:	*35065IN0030009-03*		
121		Ambetter Balanced Care 5 + Vision + Adult Dental 73% AV	35065IN0030009-04	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030009-04.pdf
						Replaced Form Number:	*35065IN0030009-04*		

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Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
122		Ambetter Balanced Care 5 + Vision + Adult Dental 78% AV	35065IN0030009-05	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030009-05.pdf
						Replaced Form Number:	*35065IN0030009-05*		
123		Ambetter Balanced Care 5 + Vision + Adult Dental 94% AV	35065IN0030009-06	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030009-06.pdf
						Replaced Form Number:	*35065IN0030009-06*		
124		Ambetter Balanced Care 2 + Vision + Adult Dental Standard	35065IN0030014-01	SCH	Initial				35065IN0030014-01.pdf
125		Ambetter Balanced Care 2 + Vision + Adult Dental Zero CS	35065IN0030014-02	SCH	Initial				35065IN0030014-02.pdf
126		Ambetter Balanced Care 2 + Vision + Adult Dental Limited CS	35065IN0030014-03	SCH	Initial				35065IN0030014-03.pdf
127		Ambetter Balanced Care 2 + Vision + Adult Dental 73% AV	35065IN0030014-04	SCH	Initial				35065IN0030014-04.pdf
128		Ambetter Balanced Care 2 + Vision + Adult Dental 87% AV	35065IN0030014-05	SCH	Initial				35065IN0030014-05.pdf
129		Ambetter Balanced Care 2 + Vision + Adult Dental 94% AV	35065IN0030014-06	SCH	Initial				35065IN0030014-06.pdf
130		Ambetter Balanced Care 1 + Vision + Adult Dental Standard	35065IN0030015-01	SCH	Initial				35065IN0030015-01.pdf
131		Ambetter Balanced Care 1 + Vision + Adult Dental Zero CS	35065IN0030015-02	SCH	Initial				35065IN0030015-02.pdf
132		Ambetter Balanced Care 1 + Vision + Adult Dental Limited CS	35065IN0030015-03	SCH	Initial				35065IN0030015-03.pdf

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133		Ambetter Balanced Care 1 + Vision + Adult Dental 73% AV	35065IN0030015-04	SCH	Initial				35065IN0030015-04.pdf
134		Ambetter Balanced Care 1 + Vision + Adult Dental 87% AV	35065IN0030015-05	SCH	Initial				35065IN0030015-05.pdf
135		Ambetter Balanced Care 1 + Vision + Adult Dental 94% AV	35065IN0030015-06	SCH	Initial				35065IN0030015-06.pdf
136		Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental Standard	35065IN0030012-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030012-01.pdf
						Replaced Form Number:	*35065IN0030012-01*		
137		Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental Zero CS	35065IN0030012-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030012-02.pdf
						Replaced Form Number:	*35065IN0030012-02*		
138		Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental Limited CS	35065IN0030012-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030012-03.pdf
						Replaced Form Number:	*35065IN0030012-03*		
139		Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental Standard	35065IN0030013-01	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030013-01.pdf
						Replaced Form Number:	*35065IN0030013-01*		
140		Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental Zero CS	35065IN0030013-02	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030013-02.pdf
						Replaced Form Number:	*35065IN0030013-02*		
141		Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental Limited CS	35065IN0030013-03	SCH	Revised	*Previous Filing Number:*	*CELT-128986928*		35065IN0030013-03.pdf
						Replaced Form Number:	*35065IN0030013-03*		
142		Ambetter Essential Care 2 + Vision + Adult Dental Standard	35065IN0030016-01	SCH	Initial				35065IN0030016-01.pdf

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TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
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Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
143		Ambetter Essential Care 2 + Vision + Adult Dental Zero CS	35065IN0030016-02	SCH	Initial			35065IN0030016-02.pdf
144		Ambetter Essential Care 2 + Vision + Adult Dental Limited CS	35065IN0030016-03	SCH	Initial			35065IN0030016-03.pdf
145		Ambetter Essential Care 1 + Vision + Adult Dental Standard	35065IN0030017-01	SCH	Initial			35065IN0030017-01.pdf
146		Ambetter Essential Care 1 + Vision + Adult Dental Zero CS	35065IN0030017-02	SCH	Initial			35065IN0030017 -02.pdf
147		Ambetter Essential Care 1 + Vision + Adult Dental Limtied CS	35065IN0030017-03	SCH	Initial			35065IN0030017-03.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your"*, *"yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

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

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

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

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

DEFINITIONS

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

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

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

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* lawful *spouse* and/or an *eligible child*.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

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

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 *generally accepted 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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

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

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

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

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

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

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:

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

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

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

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

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

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

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

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

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

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

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

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

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

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

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

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

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

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

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

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

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

Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

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

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:

   a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
   b. Daily room and board and nursing services while confined in an *intensive care unit*.
   c. *Inpatient* use of an operating, treatment, or recovery room.
   d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
   e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
   f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of*

pregnancy, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*
2. 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 that 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.

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

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

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:
1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Other Dental Services
Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage
Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

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

- 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.

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

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

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

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.

2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

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

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

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

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

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

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

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

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

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

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

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

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

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

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

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

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

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

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

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

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

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

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

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

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

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

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

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

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

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

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

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

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

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

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

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

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

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

DEFINITIONS

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

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

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

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* lawful *spouse* and/or an *eligible child*.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

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

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 *generally accepted 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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

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

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

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

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

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

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:

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

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

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

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

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

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

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

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

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

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

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

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

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

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

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

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

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

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

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

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

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

Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

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

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room.
d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of*

pregnancy, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*
2. 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 that 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.

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

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

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:
1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage

Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

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

- 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.

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

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

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

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.

6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

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

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

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

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

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

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

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

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

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

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

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

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

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

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

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

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

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

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

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

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

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

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

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

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

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

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

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

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

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

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

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

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

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

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

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

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

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

DEFINITIONS

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

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

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

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* lawful *spouse* and/or an *eligible child*.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

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

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 *generally accepted 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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

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

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

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

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

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

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:

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

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

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

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

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

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

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

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

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

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

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

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

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

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

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

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

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

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

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

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

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

Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

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

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room.
d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of*

pregnancy, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*
2. 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 that 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.

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

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

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:
1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, Basic (Class 1) and Comprehensive (Class 2) dental services from an *In-Network provider*. *Covered services* for restorative care are subject to a 6 month waiting period. Please refer to your Schedule of Benefits for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which dental providers are part of the network, please call Member Services or visit http://ambetter.mhsindiana.com/.

1. Basic (Class 1) benefits include:
   a. Routine Oral Exams;
   b. Routine Cleanings;
   c. Bite-wing X-rays;
   d. Full-Mouth X-Rays;
   e. Panoramic Film;
   f. Topical fluoride application; and
   g. Palliative Treatment for Relief of Pain (minor procedures).
2. Comprehensive (Class 2) benefits include:
   a. Basic Services – including silver filings and tooth colored filings;
   b. Endodontics – including therapeutic pulpotomy;
   c. Periodontics – including scaling, root planning and periodontal maintenance;
   d. Oral Surgery – including simple extractions, surgical extractions, removal of impacted tooth and alveoloplasty; and
   e. Prosthodontics – including relines, rebase, adjustment and repairs.

Services not covered for adult Basic (Class 1) and Comprehensive (Class 2) benefits include:

1. Out of network services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. Prescription drugs;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the member's *effective date* of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant procedures;
11. Surgical replacements;
12. Sinus augmentation;
13. Surgical appliance removal;

14. Intraoral placement of a fixation device;
15. Oral hygiene instruction, tobacco counseling, nutritional counseling;
16. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
17. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
18. Root canal therapy;
19. Analgesia (nitrous oxide);
20. Removable unilateral dentures;
21. Temporary procedures;
22. Splinting;
23. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
24. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
25. Consultations by the treating provider and office visits;
26. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's *effective date*;
27. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
28. Veneers (bonding of coverings to the teeth);
29. Orthodontic treatment procedures;
30. Corrections to congenital conditions, other than for congenital missing teeth;
31. Athletic mouth guards;
32. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment; and
33. Space maintainers for anyone 19 years of age or older.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage

Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.

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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

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

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

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

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

Ancillary "Center Of Excellence" Service Benefits:

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

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits

Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

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

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

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

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

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

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

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

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

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

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

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

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

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

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

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

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

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

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

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

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*.

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

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

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

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

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

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.
The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

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

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

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

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

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

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

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

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment*	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visit per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered

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Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular

program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3-Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3-Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Silver 3 -73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit*	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$200 Individual $400 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit*	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $200 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $200 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $200 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$50 Individual $100 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit*	$2 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $50 Prescription Drug Deductible combined with Non-Preferred and Specialty	$5 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $50 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $50 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$2 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$2 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered

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Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

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[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment*	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit*	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit*	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	$75 Copayment after Deductible	Not Covered
Specialty*	10% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered

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Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$0 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care 12 visits per year	$10 Copayment	Not Covered

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Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$100 Individual $200 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit*	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$5 Copayment	Not Covered
Non-Preferred Brand*	$25 Copayment after Deductible	Not Covered
Specialty*	5% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$50 Copayment after Deductible	$50 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Nursing Duty* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered

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Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$50 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per stay after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	$250 Copayment after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit*	$30 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$50 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility	$150 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$150 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$150 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$100 Copayment per Stay after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$100 Individual $200 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit*	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$10 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$50 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$10 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$250 Copayment after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$250 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	$250 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$250 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$100 Copayment after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$250 Copayment after Deductible	Not Covered
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit*	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$0 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$25 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	$100 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$0 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$100 Copayment per Stay after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$100 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$100 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	$100 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	$100 Copayment after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$100 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	$0 Copayment after Deductible	Not Covered
Durable Medical Equipment *	$0 Copayment after Deductible	Not Covered

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Hospice Services*	$0 Copayment after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	$0 Copayment after Deductible	Not Covered
Accidental Dental $3,000 per year	$0 Copayment after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$100 Copayment after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	Ambetter Balanced Care 2
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit*	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand *	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Diabetes Care Management*	$60 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

*Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance	$0 Coinsurance
Emergency Transportation/Ambulance (Air*or Ground)	0% Coinsurance	0% Coinsurance
Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		

 *Requires prior authorization – please contact the number listed on your ID card

• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$60 Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$4,000 Individual $8,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

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Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	0% Coinsurance after Deductible	Not Covered

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$30,000 for donor search		
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

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[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$1,500 Individual $3,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment*	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$500 Individual $1,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 Days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

*Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance
Urgent Care	$0 Copayment	Not Covered

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Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screening, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

*Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,750 Individual $3,500 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$150 Individual $300 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $150 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $150 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $150 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

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Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	Not Covere30% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$750 Individual $1,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

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Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered

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Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

*Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

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 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered
Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

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Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$0 Copayment	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

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Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Specialty*	0% Coinsurance after	Not Covered

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• $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	Prescription Drug Deductible	
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		

 *Requires prior authorization – please contact the number listed on your ID card

Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250 *The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.*

 *Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Sharing	
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

*Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

*Requires prior authorization – please contact the number listed on your ID card

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible	30% Coinsurance after Prescription Drug Deductible	Not Covered

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coinsurance charges applied		
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered

• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered

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Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered

Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visit per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered

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Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered

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• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$200 Individual $400 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $200 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $200 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $200 Prescription Drug Deductible combined	30% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered

Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$50 Individual $100 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$2 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $50 Prescription Drug Deductible combined with Non-Preferred and Specialty	$5 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $50 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $50 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$2 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$2 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be

available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

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Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit*	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered

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Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards,

available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit*	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	$75 Copayment after Deductible	Not Covered
Specialty*	10% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered

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Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$100 Individual $200 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit*	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$5 Copayment	Not Covered
Non-Preferred Brand*	$25 Copayment	Not Covered
Specialty*	5% Coinsurance after Deductible	Not Covered

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Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$50 Copayment after Deductible	$50 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Nursing Duty* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit*	$30 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$150 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$25 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$150 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$150 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered

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Skilled Nursing Facility* 90 days per year	$100 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered

• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$100 Individual $200 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit*	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$10 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$50 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$10 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Copayment after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$250 Copayment after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$250 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	$250 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$250 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$100 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$250 Copayment after Deductible	Not Covered
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit*	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$0 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$25 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	$100 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$0 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$100 Copayment after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$100 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$100 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	$100 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	$0 Copayment after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$100 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$0 Copayment after Deductible	Not Covered
Durable Medical Equipment *	$0 Copayment after Deductible	Not Covered

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Hospice Services*	$0 Copayment after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	$0 Copayment after Deductible	Not Covered
Accidental Dental $3,000 per year	$0 Copayment after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$100 Copayment after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

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Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	0% Coinsurance after Deductible	Not Covered

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$30,000 for donor search		
Diabetes Care Management*	$60 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and,

depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance	$0 Coinsurance
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance
Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		

 *Requires prior authorization – please contact the number listed on your ID card

• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor search		
Diabetes Care Management*	$60 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and,

depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$4,000 Individual $8,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after	Not Covered

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	Deductible	
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered

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Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards,

available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$1,500 Individual $3,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor search		
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and,

depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$500 Individual $1,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards,

available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	Not Covered
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

 *Requires prior authorization – please contact the number listed on your ID card

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance
Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,750 Individual $3,500 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500rescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$10 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$150 Individual $300 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $150 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $150 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$10 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$750 Individual $1,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with	50% Coinsurance after Prescription Drug	Not Covered

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Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	Not Covered
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered

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Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services*	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered
Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Sharing	
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		

 *Requires prior authorization – please contact the number listed on your ID card

• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits - Zero Cost Sharing + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision- Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$0 Copayment	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

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Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Sharing	
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 visits per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

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Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

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• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered

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• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular

program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined	$75 Copayment after Prescription Drug	Not Covered

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with Preferred and Specialty	Deductible	
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered

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Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered

• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the

requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
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• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
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• Trifocal	100% Covered after Copayment	Not Covered
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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

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• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
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Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

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[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental- Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined	$75 Copayment after Prescription Drug	Not Covered

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with Preferred and Specialty	Deductible	
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered

Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered

• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the

requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)- 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$200 Individual $400 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $200 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $200 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $200 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$50 Individual $100 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$2 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $50 Prescription Drug Deductible combined with Non-Preferred and Specialty	$5 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $50 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $50 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$2 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$2 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)- - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor research		
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

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Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

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Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor research		
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

 *Requires prior authorization – please contact the number listed on your ID card

Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	$75 Copayment	Not Covered
Specialty*	10% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor research		
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

 *Requires prior authorization – please contact the number listed on your ID card

Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$100 Individual $200 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$5 Copayment	Not Covered
Non-Preferred Brand*	$25 Copayment	Not Covered
Specialty*	5% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$50 Copayment after Deductible	$50 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Copayment after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Nursing Duty* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

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• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	$250 Copayment after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $500 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$150 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$25 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$150 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$150 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$100 Copayment after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$100 Individual $200 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$10 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$50 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$10 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$250 Copayment after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$250 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	$250 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$250 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$250 Copayment after Deductible	Not Covered
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visit and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$0 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$25 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $0 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	$100 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$0 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$100 Copayment per Stay after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$100 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$100 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	$100 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	$0 Copayment after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$100 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$0 Copayment after Deductible	Not Covered
Durable Medical Equipment *	$0 Copayment after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	$0 Copayment after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	$0 Copayment after Deductible	Not Covered
Accidental Dental $3,000 per year	$0 Copayment after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$100 Copayment after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$60 Copayment	Not Covered

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Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		

Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance	0% Coinsurance
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance
Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered

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Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered

Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics		

 *Requires prior authorization – please contact the number listed on your ID card

• Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance after	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

$10,000 for transportation and lodging $30,000 for donor search	Deductible	
Diabetes Care Management*	$60 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Routine Cleaning – 1 per 6 months	Annual Maximum	
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$4,000 Individual $8,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

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Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$10,000 for transportation and lodging $30,000 for donor search	Deductible	
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		

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Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	Ambetter Balanced Care 2 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$1,500 Individual $3,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after	Not Covered

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	Deductible	
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	0% Coinsurance after Deductible	Not Covered

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$30,000 for donor search		
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to	Not Covered

Routine Cleaning – 1 per 6 months	Annual Maximum	
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	Ambetter Balanced Care 2 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$500 Individual $1,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered

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Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor		

*Requires prior authorization – please contact the number listed on your ID card

procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

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Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other	$1,000 per covered person per calendar year	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

maximums)		
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, wells baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance

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Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)- 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent		

Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

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with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 100 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

 *Requires prior authorization – please contact the number listed on your ID card

Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,750 Individual $3,500 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$10 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$150 Individual $300 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $150 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $150 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $150 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 visits per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$750 Individual $1,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy) 60 days per year	10% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered

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Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

 *Requires prior authorization – please contact the number listed on your ID card

Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility*	40% Coinsurance after	Not Covered

90 days per year	Deductible	
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

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• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
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Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
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Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
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Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
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Vision Services – Pediatric (Up to 19 years of age)		
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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
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Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
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Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

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• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)- 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	40% Coinsurance after Deductible	Not Covered

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* • 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

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Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered

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Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)- 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

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Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

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Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

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Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

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for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

	Sharing	
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Coordinated Care Corporation	Decrease	-7.800%	-7.800%				%	%

Rate Review Detail

COMPANY:

Company Name: Coordinated Care Corporation
HHS Issuer Id: 35065

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Ambetter + Vision	35065IN002	35065-167562	5336
Ambetter	35065IN001	35065-167562	1196
Ambetter + Vision + Dental	35065IN003	35065-167562	5791

Trend Factors: N/A

FORMS:

New Policy Forms: N/A
Affected Forms: N/A
Other Affected Forms: 35065IN001, 35065IN002, 35065IN003

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 147,869
Benefit Change: Decrease
Percent Change Requested: Min: -15.2 Max: 0.6 Avg: -7.8

PRIOR RATE:

Total Earned Premium: 4,899,013.00
Total Incurred Claims: 3,674,490.00
Annual $: Min: 130.80 Max: 1,203.17 Avg: 424.30

REQUESTED RATE:

Projected Earned Premium: 60,434,597.00
Projected Incurred Claims: 51,865,897.00
Annual $: Min: 80.85 Max: 1,260.57 Avg: 408.70

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Table Template	35065IN001, 35065IN002, 35065IN003	New		IN State Rate Table Template 20140819.xlsm,

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Attachment IN State Rate Table Template 20140819.xlsm is not a PDF document and cannot be reproduced here.

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Supporting Document Schedules

Bypassed - Item:	10 Individual Checklist (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	12 Individual HMO Checklist (Accident & Health)
Bypass Reason:	N/A- Form 12(A) has been completed
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	12(A) Individual HMO Checklist (Accident & Health)
Comments:	
Attachment(s):	35065IN001 Form 12(A).PDF 35065IN002 Form 12(A).PDF 35065IN003 Form 12(A).PDF
Item Status:	
Status Date:	

Satisfied - Item:	4.1 Individual New Rate/Form Requirements (Accident & Health)
Comments:	Complied with.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	7.0 Individual Rate Adjustment Requirements (Accident & Health)
Comments:	Complied with.
Attachment(s):	

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Item Status:	
Status Date:	

Satisfied - Item:	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)
Comments:	Complied with.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	7.0(A) QHP Individual Rate Adjustment Requirements (Accident & Health)
Comments:	Complied with.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	N/A- QHP filing
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(B) EHB Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A- QHP filing
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	09 SERFF Data Field Guide (Accident & Health)
Comments:	Complied with.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Bypassed pursuant to instructions.
Attachment(s):	
Item Status:	
Status Date:	

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Bypassed - Item:	04 Major Medical Experience Workbook (Accident & Health)
Bypass Reason:	Coordinated Care's rates will be developed for 2015, similar to last year, with the same methodology using the modified version of the Milliman Health Cost Guidelines. Even though the filing is for a rate renewal of an existing product, the rates are not based on the product's experience.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	2015 Coordinated Care Corporation (IN) Actuarial Memo 20140819.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	IN State Rate Review Template 20140819.xlsm
Item Status:	
Status Date:	

Bypassed - Item:	03 PPACA Uniform Compliance Summary
Bypass Reason:	These forms were submitted last year and are in Compliance with PPACA requirements pursuant ot the PPACA Compliance summary submitted in SERFF Filing CELT-128986928. Please see the EHB Crosswalks for confirmation of all ACA Requirements.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Plan Name Mapping 2014 to 2015
Comments:	As referenced in the cover letter, please see the attached mapping for the 2014 plans to the new naming convention for 2015.
Attachment(s):	Mapping 2014 to 2015 Plan Names.pdf
Item Status:	
Status Date:	

Satisfied - Item:	EHB Crosswalk Tools
Comments:	

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Attachment(s):	35065IN001 EHB Crosswalk Tool.PDF 35065IN002 EHB Crosswalk Tool.PDF 35065IN003 EHB Crosswalk Tool.PDF
Item Status:	
Status Date:	

Satisfied - Item:	On/Off Exchange Attestation
Comments:	
Attachment(s):	On Off Exchange Attestation.PDF
Item Status:	
Status Date:	

Satisfied - Item:	Certificate of Readability
Comments:	
Attachment(s):	Cert of Readability.PDF
Item Status:	
Status Date:	

Satisfied - Item:	Off Exchange APTC Attestation and Disclosure
Comments:	
Attachment(s):	Off Exchange APTC Attestation.PDF Off Exchange APTC Disclosure.PDF
Item Status:	
Status Date:	

Satisfied - Item:	IN State Additional Exhibits
Comments:	
Attachment(s):	IN State Additional Exhibits 20140819.xlsb
Item Status:	
Status Date:	

Satisfied - Item:	IN Actuarial Appendices
Comments:	
Attachment(s):	IN State Appendices 20140819.xlsb
Item Status:	
Status Date:	

Satisfied - Item:	Redlined EOCs

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Comments:	
Attachment(s):	35065IN001 Redlined.pdf 35065IN002 Redlined.pdf 35065IN003 Redlined.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlined Schedule
Comments:	Please note that only one schedule which highlights what was changed on all schedules has been submitted. Should you have any questions we would be happy to discuss.
Attachment(s):	SOB Edits to 2014 Plans.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlined EOC's with changes pursuant to 5-28-14 Objection
Comments:	
Attachment(s):	35065IN001 Redlined2.pdf 35065IN002 Redline2.pdf 35065IN003 Redline2.pdf
Item Status:	
Status Date:	

Satisfied - Item:	20140602ObjectionResponse
Comments:	
Attachment(s):	IN Objections 20140519.pdf Attachments for Response to Indiana 20140519 Objections.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Response to Objections received 6-25-14
Comments:	
Attachment(s):	Objection Response 20140703.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlined EOC regarding Dental Benefits
Comments:	
Attachment(s):	35065IN0030017-03 redlined dental change.pdf
Item Status:	

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Status Date:	

Satisfied - Item:	AV Screenshots for plans marked as Unique
Comments:	
Attachment(s):	35065IN0010009.pdf 35065IN0020009.pdf 35065IN0030009.pdf
Item Status:	
Status Date:	

Satisfied - Item:	20140819 Resubmission Cover Letter
Comments:	
Attachment(s):	Coordinated Care Resubmission Cover Letter 20140819.pdf
Item Status:	
Status Date:	

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Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name Coordinated Care Corporation, dba MHS **NAIC #** 95831

Form number(s) 35065IN001 **Filing date** 05/09/2014

Product Type: ☑ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☐ **Off-Exchange** ☑ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2
B. Required Provisions 4
C.HMO Individual A&H Policies *must provide* 7
D. General Regulatory Issues 9
E. HMO Individual A&H must cover 10
F. ACA Must Provide 11
G. Specific Requirements for Qualified Health Plans 26
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	Included	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	Attached	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	The templates will be provided on or before June 3, 2014.	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	Attached	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	Cover letter in the description box.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	N/A	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	Acknowledged.	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	Attached.	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	1	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	25	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	28-29	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	32	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	28	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	See Schedule of Benefits.	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	42-44	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	45	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	45-46	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	5	
IC 27-13-36.2	**CLEAN CLAIMS**	51-53	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	55-59	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	45	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	16- Loss of Min. Essential Cov.	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	45	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	48-50	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	47	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	21	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	61	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	28-40 and Schedule of Benefits	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	45	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	1	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	45-46	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	27	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	61	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	1	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	11, 25	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	54-60	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	60	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	29-30	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	25	
IC 27-8-5-21	**ADOPTED CHILDREN**	23	
IC 27-8-5.6-2(b)	**NEWBORNS**	23	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	33, #15	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	34, #4	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	33, #17; 37	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	Comply	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	36, #3	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	Comply	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	45	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	36	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:**-Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	33, #14	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	29-30	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	Comply	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	34	
Bulletin 172	**CHEMOTHERAPY PARITY**	34, #2	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	Comply	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	N/A- Application is that used by the Exchange.	
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.	Comply	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	Comply.	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	Comply.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	Comply.	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	Comply.	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	Comply.	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	Comply.	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	Comply.	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	30	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	37	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	38	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	38	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	N/A	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	37	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	32, #2	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	5; 32, #1(f)	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	32 (1)	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	33, #17; 37-38	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	29-30	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	34-35	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	30-31	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	33, #7	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	36	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit **– PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	Pediatric Vision- 35. Pediatric dental is being excluded from the essential health benefits in lieu of an Exchange certified stand alone dental plan.	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	Acknowledge. 4, #13	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	Acknowledge.	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	Acknowledge.	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	Acknowledged.	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	Acknowledge.	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	Acknowledge.	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	Acknowledge. 26	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge. 25 & 26	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	Acknowledge. 21; 29	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	Acknowledge.	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	Acknowledge. 1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	1; 45-46	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	45	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	Acknowledge. 45	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	N/A	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	Acknowledge. 34-35	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	See Schedule of Benefits. 41	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	N/A	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	Comply.	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	27; 45, #1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	27	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	Comply.	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	Excluded, 42, #7	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	1	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	Acknowledge.	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: Michelle

Printed Name: Michelle C. Fitzpatrick

Title: Compliance Analyst

Company: Centene Corporation

Date: 05/09/2014

Checklist Reference No. 12(A)
Revised 4/17/14

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name Coordinated Care Corporation, dba MHS **NAIC #** 95831

Form number(s) 35065IN002 **Filing date** 05/09/2014

Product Type:	☑	**Major Medical**	☐	**Pediatric Stand-Alone Dental**
Exchange Participation:	☐	**Off-Exchange**	☑	**On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2
B. Required Provisions 4
C.HMO Individual A&H Policies *must provide* 7
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E. HMO Individual A&H must cover 10
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H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	Included	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	Attached	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	The templates will be provided on or before June 3, 2014.	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	Attached	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	Cover letter in the description box.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	N/A	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	Acknowledged.	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	Attached.	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	1	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	25	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	28-29	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	32	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	28	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	See Schedule of Benefits.	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	43-45	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	46	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	46-47	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	5	
IC 27-13-36.2	**CLEAN CLAIMS**	52-54	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	56-60	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	46	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	16- Loss of Min. Essential Cov.	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	46	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	49-51	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	48	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	21	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	62	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	28-41 and Schedule of Benefits	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	46	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	1	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	46-47	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	27	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	62	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	1	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	11, 25	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	55-61	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	61	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	29-30	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	25	
IC 27-8-5-21	**ADOPTED CHILDREN**	23	
IC 27-8-5.6-2(b)	**NEWBORNS**	23	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	33, #15	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	34, #4	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	33, #17; 39	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	Comply	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	37, #3	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	Comply	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	46	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	37	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:-**Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	33, #14	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	29-30	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	Comply	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	34	
Bulletin 172	**CHEMOTHERAPY PARITY**	34, #2	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	Comply	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	N/A- Application is that used by the Exchange.	
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.	Comply	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	Comply.	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	Comply.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	Comply.	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	Comply.	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	Comply.	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	Comply.	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	Comply.	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	30	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	37	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	38	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	38	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	N/A	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	38	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	32, #2	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	5; 32, #1(f)	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	32 (1)	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	33, #17; 38-39	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	29-30	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	34-35	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	30-31	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	33, #7	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	37	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit **– PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	Pediatric Vision- 35. Pediatric dental is being excluded from the essential health benefits in lieu of an Exchange certified stand alone dental plan.	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	Acknowledge. 4, #13	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	Acknowledge.	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	Acknowledge.	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	Acknowledged.	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	Acknowledge.	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	Acknowledge.	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	Acknowledge. 26	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge. 25 & 26	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	Acknowledge. 21; 29	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	Acknowledge.	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	Acknowledge. 1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	1; 46-47	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	46	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	Acknowledge. 46	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	N/A	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	Acknowledge. 34-35	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	See Schedule of Benefits. 42	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	N/A	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	Comply.	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	27; 46, #1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	27	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	Comply.	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	Excluded, 43, #7	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	1	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	Acknowledge.	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: Michelle

Printed Name: Michelle C. Fitzpatrick

Title: Compliance Analyst

Company: Centene Corporation

Date: 05/09/2014

Checklist Reference No. 12(A)
Revised 4/17/14

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name Coordinated Care Corporation, dba MHS **NAIC #** 95831

Form number(s) 35065IN003 **Filing date** 05/09/2014

Product Type: ☑ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☐ **Off-Exchange** ☑ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2

B. Required Provisions 4

C.HMO Individual A&H Policies *must provide* 7

D. General Regulatory Issues 9

E. HMO Individual A&H must cover 10

F. ACA Must Provide 11

G. Specific Requirements for Qualified Health Plans 26

H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	Included	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	Attached	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	The templates will be provided on or before June 3, 2014.	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	Attached	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	Cover letter in the description box.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	N/A	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	Acknowledged.	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	Attached.	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	1	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	25	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	28-29	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	32	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	28	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	See Schedule of Benefits.	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	44-46	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	47	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	47-48	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	53-55	
IC 27-13-36.2	**CLEAN CLAIMS**	53	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	56-60	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	47	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	16- Loss of Min. Essential Cov.	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	47	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	50-52	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	49	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	21	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	63	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	28-42 and Schedule of Benefits	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	47	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	1	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	47-48	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	27	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	63	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	1	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	11, 25	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	56-62	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	62	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	29-30	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	25	
IC 27-8-5-21	**ADOPTED CHILDREN**	23	
IC 27-8-5.6-2(b)	**NEWBORNS**	23	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	33, #15	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	34, #4	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	33, #17; 39	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	Comply	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	38, #3	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	Comply	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	47	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	38	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:**-Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	33, #14	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	29-30	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	Comply	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	34	
Bulletin 172	**CHEMOTHERAPY PARITY**	34, #2	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	Comply	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	N/A- Application is that used by the Exchange.	
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.	Comply	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	Comply.	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	Comply.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	Comply.	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	Comply.	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	Comply.	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	Comply.	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	Comply.	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	30	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	39	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	39	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	39	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	N/A	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	39	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	32, #2	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	5; 32, #1(f)	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	32 (1)	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	33, #17; 39-40	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	29-30	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	34-35	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	30-31	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	33, #7	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	38	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	Pediatric Vision- 35. Pediatric dental is being excluded from the essential health benefits in lieu of an Exchange certified stand alone dental plan.	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	Acknowledge. 4, #13	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	Acknowledge.	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	Acknowledge.	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	Acknowledged.	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	Acknowledge.	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	Acknowledge.	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	Acknowledge. 26	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge. 25 & 26	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	Acknowledge. 21; 29	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	Acknowledge.	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	Acknowledge. 1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	1; 47-48	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	47	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	Acknowledge. 47	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	N/A	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	Acknowledge. 33-34	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	See Schedule of Benefits. 43	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	N/A	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	Comply.	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	27; 47, #1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	27	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	Comply.	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	Excluded, 44, #7	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	1	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	Acknowledge.	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, <u>either on or off the Exchange</u>. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: Michelle

Printed Name: Michelle C. Fitzpatrick

Title: Compliance Analyst

Company: Centene Corporation

Date: 05/09/2014

Actuarial Memorandum

Coordinated Care Corporation

Individual Health Rate Filing

Effective January 1, 2015

Forms: 35065IN001, 35065IN002, 35065IN003

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1. General Information

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Coordinated Care Corporation's Individual health block of business, effective January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This actuarial memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene, parent company of Coordinated Care Corporation, and Milliman, Inc. dated January 13, 2003. This information is intended for use by the Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Coordinated Care Corporation's Individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for Coordinated Care Corporation by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions. This is a renewal rate filing. The purpose of this filing is to meet the requirements of the State of Indiana statutes and demonstrate that the benefits are reasonable in relation to the premium charged.

Company Identifying Information:

- Company Legal Name: Coordinated Care Corporation
- State: The State of Indiana has regulatory authority over these policies.
- HIOS Issuer ID: 35065
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information:

- Primary Contact Name: Jon Szerszen
- Primary Contact Telephone Number: (312) 332-8560
- Primary Contact Email Address: jszerszen@celtic-net.com

Description of Benefits:

These products are HMO health policies issued by Coordinated Care Corporation. Each plan below can be a stand-alone plan, have adult vision coverage, or have both adult vision and adult dental coverage. The major provisions of this form for each plan design and product are as follows:

Plan Design	Med Deductible	Plan Coins	Rx Deductible	OOP Max	PCP Visit	Spec Visit	Rx Copay
Ambetter Secure Care 2	$500	80%	$500	$6350	$50 NSD	$75 NSD	$15 NSD/$30 SD/$100 SD/30% SD / Max $350
Ambetter Secure Care 1 with 3 Free PCP Visits	$1000	80%	$500	$6350	D&C	D&C	$10 NSD/$25 SD/$75 SD/30% SD / Max $350
Ambetter Balanced Care 3	$2500	70%	$1000	$6350	$50 NSD	$75 NSD	$20 NSD/$50 SD/$100 SD/D&C / Max $350
Ambetter Balanced Care 4	$2000 INT	80%	INT	$6350	$50 NSD	$75 NSD	$20 NSD/$50 NSD/$100 SD/D&C
Ambetter Balanced Care 5	$3000	100%	$1000	$6350	$50 NSD	$75 NSD	$10 NSD/$50 SD/$75 SD/$250 SD
Ambetter Balanced Care 1	$5000	70%	$750	$6350	$25 NSD	$50 NSD	$10 NSD/$60 SD/50% SD/50% SD
Ambetter Balanced Care 2	$5000 INT	100%	INT	$5000	$30 NSD	$60 NSD	$10 NSD/$50 NSD/D&C/D&C
Ambetter Essential Care 2	$5000 INT	60%	INT	$6500	D&C	D&C	$25 NSD/$50 SD/$100 SD/D&C
Ambetter Essential Care 1	$6500 INT	100%	INT	$6500	D&C	D&C	$20 NSD/D&C/D&C/D&C
Ambetter Essential Care 3 with 3 Free PCP Visits	$6000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$50 SD/$100 SD/30% SD / Max $350
Ambetter Essential Care 4 with 3 Free PCP Visits	$4000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$100 SD/$150 SD/30% SD / Max $350

D&C – Deductible and Coinsurance

INT – Integrated Medical and Rx Deductible

NSD – Not subject to deductible

SD – Subject to deductible

Rx Copay – Generic / Preferred Brand / Non-Preferred Brand / Specialty

Rate Guarantees:

Rates are guaranteed not to change through December 31, 2015.

Renewability:

Each policy is renewable by paying the applicable renewal premiums unless the policy holder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability:

The rates will apply to new and renewing business.

General Marketing Method:

This product will be sold through agents, direct mailings, the internet, and the Federally Facilitated Exchange.

Estimated Average Annual Premium:

The following is a comparison of estimated average annual premium per policy:

Date	Nationwide*	Indiana
Calendar Year 2015	$4,904	$4,904

*Note that the products to which this rate filing applies are offered only in Indiana.

Distribution of Business:

See Appendix A for the expected age and geographic distributions for these products.

Rate Tables:

See Appendix B for base rate and allowable rating factors. Appendix B also includes an example of how rating factors will be applied. Note that for family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Patient Protection and Affordable Care Act (ACA).

The geographic factors are developed based upon contractual reimbursement and provider practice pattern differences in each of the established rating areas. Based upon the expected distribution of enrollment by area, the geographic factors reflect the single risk pool results consistent with the URRT. The geographic factors for unit cost and utilization differences within the manual rate model vary by Metropolitan Service Area (MSA), and are a component to the geographic factor. To the extent the established rating area is a subset of an MSA, the manual rate model geographic factors are supplemented with county specific unit cost relativities.

The age band factors are prescribed through the ACA guidance.

The tobacco factors are developed based on Milliman research and are within the 1.0 to 1.5 tobacco factor range.

Premium Modalization:

Premiums will be collected only on a monthly basis.

Trend Assumption:

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2. Proposed Rate Increase(s)

The rate increases for each product offered by Coordinated Care Corporation in the State of Indiana are reflected in Worksheet 2, Section I of the Part I URRT.

Reasons for Rate Increase(s):

The rate projections for 2015 have been updated from the previous year's projections to reflect the most recent information available.

Here is a description of the significant factors driving the proposed rate increase for 2015:

- Change in Single Risk Pool Experience

  The morbidity for the Individual market population in 2015 was estimated using the Milliman State Impact Model (SIM). There is a full description of this model in the Credibility Manual Rate Description section.

- Unit Cost Trend

  Unit costs and reimbursement agreements with providers have changed between 2014 and 2015.

- Utilization Trend

  The Milliman *Health Cost Guidelines* underlying the rate projections have been updated to reflect projected changes in utilization from 2014 to 2015. There is a full description of this model in the Credibility Manual Rate Description section.

- Prospective changes to benefits covered by the product or successor products

  The benefits covered are not expected to change during the effective period.

- New taxes and fees imposed on the issuer

  Premium rates have been adjusted to reflect the schedule of taxes and fees for 2015. While there were no new tax categories added between 2014 and 2015, the rates of the taxes changed. For the Health Insurance Provider Fee, the percentage was recalculated to reflect that the federal government plans on collecting $11.3 billion for 2015, compared to $8.0 billion for 2014. The Patient Centered Outcomes Research Fee has been increased from the 2014 amount.

- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

Assumptions for the Federal Transitional Reinsurance Program have been updated for 2015. Both the fee charged and the expected benefits will change from 2014 to 2015. Here are the specific changes in parameters from 2014 (as of the time of pricing in May 2013) to 2015:

- Claims attachment point: Changing from $60,000 to $70,000
- Reinsurance Cap: Remaining at $250,000
- Coinsurance Rate: Changing from 80% to 50%.
- Reinsurance Issuer Fee: Changing from $5.25 PMPM to $3.67 PMPM.

3. Experience Period Premium and Claims

Not applicable. At the time of this filing, data was not available.

4. Benefit Categories

The Milliman Health Cost Guidelines (HCG) were used to categorize the projected claims into the benefit categories in Worksheet 1, Section II. The detailed benefit categories from the HCGs were then consolidated into the categories shown on Worksheet 1, Section II of the Part I URRT. See Appendix C for a description of this mapping.

5. Projection Factors

Not applicable. This is a filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6. Credibility Manual Rate Development

Source and Appropriateness of Experience Data Used

Expected morbidity for the Indiana Individual market population in 2015 was estimated using the Milliman State Impact Model (SIM). The SIM is designed to model population shifts across insurance markets due to health reform and quantify the impact of these shifts on the composite morbidity for each market.

The SIM combines demographic data from the American Community Survey, the Current Population Survey, and cost data from CCIIO MLR reports in order to develop a comprehensive picture of Indiana's pre-ACA marketplace by insurance coverage (including uninsured), age, gender, income, and self-reported health status.

Morbidity factors based on two Milliman tools: the Health Cost Guidelines; and the Small Group Medical Underwriting Guidelines; are assigned to each member in the population. The morbidity factors vary based on the member's age, gender, and self-reported health status.

The impact of health reform on the Indiana insurance markets is modeled by transitioning enrollees across insurance coverage categories, assuming a static population. Modeled transitions include the following:

-Employer Plan Termination
-Voluntary Employee Termination and Early Retirement
-Uninsured Insurance Participation
-Disenrollment from the Individual Market as a Reaction to Post-ACA Community Rating
-Exchange Participation by Existing Off-Exchange Individual Insurance Enrollees
-State and Federal High Risk Pool Termination

Transition rates vary by insurance coverage, age, gender, income, and self-reported health status. Aggregate transition rates between insurance coverage pairs were initially calibrated based on aggregate transition rates from the March 2013 SOA/Optum Study "Cost of the Future Newly Insured under the Affordable Care Act (ACA)"[1], and subsequently adjusted based on implied individual Exchange enrollment rates through February 1, 2014 published in the February 12, 2014 ASPE Issue Brief "Health Insurance Marketplace: February Enrollment Report"[2].

Composite morbidity is then calculated for each pre-ACA and post-ACA insurance market based on the distribution of membership by age, gender, and self-reported health status. A Pent-Up Demand

[1] http://www.soa.org/NewlyInsured/

[2] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

adjustment is applied to the morbidity of the newly insured (those who transitioned from uninsured to insured), ranging from 2.5% for members reporting in Excellent or Very Good health to 5% for members in Good or Fair/Poor health.

The composite morbidity factors were then used to calibrate the Managed Care Rating Model (MCRM) to the projected Individual population for Indiana by scaling utilization in the model's basic tables to reflect the ratio of pre-ACA Large Group morbidity which is the MCRM base assumption to projected post-ACA Individual On-Exchange morbidity from the SIM.

The manual rate development is based on the calibrated MCRM and the companion HCGs. The MCRM includes several adjustments from the HCGs to adjust to be consistent with the expected individual population that will be enrolled for geographic area utilization relativities, expected provider reimbursement, and utilization management programs.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverage levels.

The Milliman HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

Market-wide rates were developed based on the adjusted MCRM, and we used the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

Adjustments Made to the Data

The following adjustments were made to calibrate the pricing model to the expected population:

-Rating region
-Expected demographics
-Expected morbidity
-Provider Reimbursement
-Expected utilization management savings
-Benefit plan designs

Transition from ICD9 to ICD10

Centene assumes that the coding cost impact of transitioning from ICD-9 to ICD-10 will be immaterial and is making no pricing adjustment for this transition. To make this determination, Centene reviewed several external studies and conducted an internal study. These studies priced an identical set of claims coded in both ICD-9 and ICD-10 (simulated by using General Equivalence Mappings). Although some conditions coded under ICD-10 had a higher cost than ICD-9, others had a lower cost. Centene's internal study also found that some provider's cost levels increased under ICD-10 while others decreased. After a review of all studies, Centene concluded that these positive and negative variances served to cancel each other out. Hence, the decision was made to make no adjustment for this transition.

Inclusion of Capitation Payments

Capitated payments for services are accounted for through a PMPM allocation to claims, where the average capitation amount replaces the projected claims amount.

7. Credibility of Experience

Coordinated Care Corporation does not have credible experience on which to base rate development. The product became effective on January 1, 2014. As a result of the immature claims experience and volatile membership to date, there is insufficient claims experience to support premium development. We used a credibility percentage of 0%, for the purposes of the rate projection.

8. Paid to Allowed Ratio

The Paid to Allowed Average Factor in the Projection Period for the market is shown on Worksheet 1, Section III.

This ratio was developed by compositing values from the pricing model by plan. The pricing model that develops the plan cost relativities calculates per member per month costs on both an allowed and paid basis. The paid to allowed ratios for each plan in Worksheet 2 were composited using the projected membership in Worksheet 2. This calculation is shown in Appendix D.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

The first step to developing the risk adjustment transfer payment is to summarize the projected enrollment by age, gender, plan design, and income (relative to the federal poverty level), and make estimates of each component of the risk transfer formula for each enrollment cell. These estimates are then aggregated using projected statewide and Coordinated Care Corporation enrollment to determine the portfolio average risk transfer payment or receivable, which is then proportionally allocated to all plans in the portfolio.

The risk transfer calculations are based on the risk adjustment transfer formula, as provided in the Federal Register Volume 78 Number 47, and displayed below. The "HHS Notice of Benefit and Payment Parameters for 2015", which was made final March 11, 2014, states that the 2015 risk adjustment parameters are the same as those used for the 2014 plan year.

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \overline{P_s}$$

Where:

$\bar{P}_s$= State average premium

$PLRS_t$ = plan i's plan liability risk score;

AV_i= plan i's metal level AV;

ARF_i= plan i's allowable rating factor;

IDF_i = plan i's induced demand factor;

GCF_i = plan i's geographic cost factor;

s_i = plan i's share of State enrollment as measured in member months;
and the denominator is summed across all plans in the risk pool in the market in the State.

For the purpose of our modeling, each of these factors was approximated as follows.

$\overline{P}$: For the State Average Premium, it was assumed the average statewide premium is approximately $426 PMPM.

PLRS: The risk score is approximated as the product of factors from two models:

1) Average Health and Human Services Hierarchical Condition Category (HHS-HCC) Risk Adjustment score by age and gender and metal level AV for the pre-reform Individual Market, developed using Truven Market Scan data;
2) Morbidity of the 2015 statewide Individual Market risk pool and 2015 On-Exchange population morbidity, relative to the pre-reform Individual Market average by age and gender, adjusted for the expected efficiency of the HHS-HCC Risk Adjuster

The HHS-HCC code was adapted from the published rules relating to market reform.

The previous section Credibility Manual Rate Development describes the development of the SIM enrollment and morbidity estimates, based on data and assumptions regarding the distribution of health status by insurance coverage pre-reform and insurance coverage transitions through 2015. The SIM estimates relative morbidity from each population's relative composition by age, gender, and self-reported health status.

IDF: The induced demand factors are provided in the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.

AV: The actuarial value is provided in the March 11, 2013 Federal Register, page 15433, Table 9. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold, 0.80, and Platinum 0.90.

ARF: As stated in the March 11, 2013 Federal Register, page 15433, the allowable rating factor adjustment accounts only for age rating. The adjustment uses the HHS age rating factors blended to the anticipated enrollment age band level. An equal distribution for each age within each age band was assumed.

GCF: No adjustment was assumed for the geographic rating factors.

This calculation results in an estimated per member risk adjustment relativity factor for each enrollment cell, which when multiplied by the state-wide average premium gives the estimated per member per month transfer payment. These transfer payments are then composited over enrollment for all plans to estimate the total and proportionally distributed relative to premium for each plan.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

The 2015 Transitional Reinsurance program payout parameters, applicable to members in the Individual market, are:

- $70,000 claims attachment point
- $250,000 reinsurance cap
- 50% coinsurance rate

The anticipated payments from this temporary program in 2015 are equivalent to approximately 6.7% of premium.

This estimate was derived by considering the claim probability distribution adjusted to reflect the estimated paid PMPM underlying the modified MCRM pricing model, given the payment parameters stated above. HHS will assess $3.67 PMPM to fund the transitional reinsurance program in 2015. The expected transitional reinsurance recovery is $27.41 PMPM. The net reinsurance recovery is then $23.74 PMPM and is allocated proportionally based on plan premiums across all plans.

Temporary Risk Corridor:

No adjustment was made to the Index rate due to the temporary risk corridor program. Although no adjustment was made in pricing for the risk corridor program, it is still possible that risk corridor transfer payments could be made, depending on actual experience. There is risk borne by carriers due to changes and uncertainties in the market stabilization program.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

Based on our membership projections, we have projected that we need $49.13 PMPM to cover administrative expenses. This allowance is estimated to appropriately cover expenses for overhead, operations, sales, distribution, and marketing expenses.

We have estimated an additional $1.88 PMPM to cover approved quality improvement expenses and $2.00 PMPM to cover provider incentive payments.

The administrative expenses are allocated proportionally by plan.

Profit (or Contribution to Surplus) & Risk Margin:

The proposed rates reflect 5.00% of premium as a risk/profit margin. This load was applied to all products and plans.

Taxes and Fees:

The following taxes and fees are included in the non-benefit expenses:

$2.00 Per Member Per Year for the Patient Centered Outcomes Research Fee (0.04% of Premium)
$1.00 Per Member Per Year for the Risk Adjustment User Fee (0.02% of Premium)
3.00% of premium for the Health Insurance Provider Fee
1.30% of premium for State of Indiana Premium Tax assessments
3.50% of premium for Federally Facilitated Exchange fee
0.40% of premium for anticipated assessments (high risk pool)

The Federal transitional reinsurance contribution of $3.67 PMPM is netted out of the reinsurance recoverable, as described in the previous section. It is not included as a non-benefit expense.

11. Projected Medical Loss Ratio

The projected medical loss ratio is 83.0%. This loss ratio is calculated consistently with the federal MLR methodology. See table below for the calculation.

a)	Incurred Claims	$354.64
b)	Risk Adjustment Transfer	($25.52)
c)	Transitional Reinsurance Payment	($27.41)
d)	Adjusted Incurred Claims (a+b+c)	$301.71
e)	Reinsurance Premium	$3.67
f)	Worksheet 1 Projected Incurred Claims (d+e)	$305.38
g)	Administrative Expenses	$49.13
h)	Profit and Contribution to Surplus	$20.44
i)	Taxes and Fees	$33.76
j)	Premium (f+g+h+i)	$408.70
k)	Federal Income Tax	$7.15
l)	State Income Tax	$0.80
m)	Medical Loss Ratio (d/(j-e-i-k-l))	83.0%

The expected Lifetime Loss Ratio is 74.7% [=(f) / (j)].

12. Single Risk Pool

The index rate is based on the Single Risk Pool set by the State of Indiana, which was established according to the requirements in 45 CFR Part 156.80(d). The Single Risk Pool is defined as the non-grandfathered Individual business in Indiana.

13. Index Rate

The Index Rate for the Experience Period has been left blank, since there is not credible experience on which to base the rate development.

The Index Rate for the Projection Period (calendar year 2015) is reflected in Section III, worksheet 1 of the URRT.

The Index Rate for the Projection Period represents the estimated total combined projected allowed claims PMPM for essential health benefits (EHB) for calendar year 2015, and has not been adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees. The total allowed claims include benefits in excess of EHBs (Acupuncture, Adult vision coverage, and Adult dental coverage). Pediatric dental is not included in the benefit package since this will be offered through a stand-alone plan on the Exchange. The index rate was calculated based on the results of the Credibility Manual Rate Development, detailed above. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

The development of the projection Index Rate is found in Section II of worksheet 1. The projection period Index Rate reflects:

- The 12 months projection period shown in Worksheet 1, Section II.
- The anticipated claim level of the projection period with respect to trend, benefit and demographics
- The experience of all policies expected to be in the single risk pool (with necessary adjustments)

Appendix E demonstrates the flow of the rate development from the projection Index Rate to the Consumer Adjusted Premium Rates. The next three sections further describe the steps of the rate development shown in Appendix E.

14. Market Adjusted Index Rates

The Index Rate was then adjusted to arrive at a Market Adjusted Index Rate, based on the following allowable adjustments, as outlined in 45 CFR 156.80(d):

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

The reinsurance and risk adjustments are described above in the Reinsurance and Risk Adjustment section.

The Exchange user fee is 3.5% of premium.

Appendix E shows the development of the Market Adjusted Index Rate.

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rate is the Market Adjusted Index Rate adjusted for any of the following allowable adjustments, where applicable, as outlined in 45 CFR 156.80(d):

- The actuarial value and cost-sharing design of the plan
- Provider network, delivery system and utilization management adjustment
- The benefits provided under the plan that are in addition to the essential health benefits
- Adjustment for distribution and administrative costs

Administrative costs and Other Benefits (non-EHB) common to all plans are added to the Market Adjusted Index Rate and then factors for actuarial value and cost sharing, tobacco surcharge and non-EHBs by plan are applied to reach the Plan Adjusted Index Rates by plan.

The development and values of the Plan Adjusted Index Rates are shown in Appendix E.

16. Calibration

Calibration factors reflecting the allowable rating factors are applied to the Plan Adjusted Index Rates in order to calculate the Consumer Adjusted Premium Rates. The calibration factors for each of the age factors and geographic factors are shown in Appendix E. Note that each of the calibration factors has one value that is applied uniformly and does not vary by plan.

Age Curve Calibration

The age curve calibration factor applied in Appendix E is calculated by weighting the prescribed age rating factors with the single risk pool membership distribution. The age factor for each age band is the simple average of the factors in that band. The weighted average age that corresponds to this age calibration factor is 47 years.

Appendix E of the Actuarial Memorandum demonstrates the step of applying the age calibration factor to the Plan Adjusted Index Rate to get to the Consumer Adjusted Premium Rates.

Geographic Factor Calibration

The geographic rating factors are displayed in Appendix B.

17. Consumer Adjusted Premium Rate Development

Each Plan Adjusted Index Rate is divided by the overall calibration factor to determine the Consumer Adjusted Premium Base Rate.

The following allowable rating factors, as specified by 45 CFR Part 147.102, are applied to the Consumer Adjusted Premium Base Rate to determine the rate that is charged to the health insurance purchaser:

- Rating area
- Age
- Tobacco status
- For family coverage, rates for children are charged to no more than the three oldest covered children under age 21

Appendix B lists the allowable rating factors and has an example calculation of a family's rates.

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I URRT were based on the Federal AV Calculator. Please refer to Appendix F for screen shots documenting the outcomes of the AV Calculator for each plan.

19. AV Pricing Values

For each plan, we have indicated the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). See Appendix G for this development.

Each plan's AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. The AV Pricing Values reflect the relative impact of the following items:

- The plan's provider network, delivery system characteristics and utilization management
- The actuarial value and cost sharing design of the plan
- The additional expected cost of non-essential health benefits provided under each plan
- Administrative costs, excluding Exchange user fees
- Tobacco surcharge

The benefit relativities were developed using the MCRM, as described in the Credibility Manual Rate Development section. Since these products were first offered effective 1/1/2014, and Coordinated Care Corporation does not have experience on which to base the rate development, the MCRM was used to develop the benefit relativities for the AV Pricing Values.

Market-wide rates were developed based on the MCRM using the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

20. Membership Projections

Statewide individual market enrollment projections were developed from the same State Impact Model (SIM) projections used to estimate individual market morbidity (see the "Credibility Manual Rate Development" section for more details). Coordinated Care Corporation adjusted the projections for specific expectations regarding Medicaid MCO and Health Plan market share. Specifically, adjustments were made to reflect the proportion of enrollees by income selecting a Medicaid MCO that offers individual insurance on the exchange. Of the proportion of enrollment that select a Medicaid MCO offering individual insurance, the Health Plan made assumptions regarding expected membership based on the portion of this segment in each county that is in line with its current market share of Medicaid Managed Care business in that county.

For Silver plan membership, the portion of the projected enrollment that will be eligible for cost sharing reduction subsidies at each subsidy level was based on the income level detail in the enrollment projections. The detail of the projected membership by subsidy level is shown in Appendix H.

21. Terminated Products

No products will be terminated.

22. Plan Type

Not applicable. The Plan types listed in Worksheet 2, Section I of the Part I URRT describe Coordinated Care Corporation's plans exactly.

23. Warning Alerts

There are no warning alerts in the URRT.

24. Effective Rate Review Information

The following section is provided to facilitate rate review by the Indiana Department of Insurance. The content provided follows the section "III Actuarial Memorandum" of the filing instructions named "7.0(A) Qualified Health Plans (QHPs) Individual Rate Requirements for Major Medical, HMO and Dental".

24.1. Benefit Structure

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Coordinated Care Corporation's Individual health block of business, effective January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This actuarial memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene, parent company of Coordinated Care Corporation, and Milliman, Inc. dated January 13, 2003. This information is intended for use by the Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Coordinated Care Corporation's Individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for Coordinated Care Corporation by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions. This is a renewal rate filing. The purpose of this filing is to meet the requirements of the State of Indiana statutes and demonstrate that the benefits are reasonable in relation to the premium charged.

Company Identifying Information:

- Company Legal Name: Coordinated Care Corporation
- Market: Individual
- Prior SERFF Tracking Number: CELT - 128986928

A copy of the policy form is attached as part of this filing.

The benefits provided fall into four categories:

- Essential Health Benefits: All plans provide coverage for the essential health benefits as prescribed through ACA guidance and as covered by the benchmark plan for Indiana.
- State Mandated Benefits Which are Not Essential Health Benefits: There are no state mandated benefits which are not essential health benefits.
- Additional Mandatory Supplemental Benefits: The plans offered under this filing do not include any additional mandatory supplemental benefits.
- Additional Optional Supplemental Benefits: Each medical plan design, as described below, is available with adult vision coverage or with adult vision and adult dental coverage.

This rate filing proposes changes to the previous filing for the base rate, rating factors, non-benefit expenses and the plans offered. The covered benefits have not changed from the previous filing.

These products are HMO health policies issues by Coordinated Care Corporation. Each plan below can be a stand-alone plan, have adult vision coverage, or have both adult vision and adult dental coverage. The major provisions of this form for each plan design and product are as follows:

Plan Design	Med Deductible	Plan Coins	Rx Deductible	OOP Max	PCP Visit	Spec Visit	Rx Copay
Ambetter Secure Care 2	$500	80%	$500	$6350	$50 NSD	$75 NSD	$15 NSD/$30 SD/$100 SD/30% SD / Max $350
Ambetter Secure Care 1 with 3 Free PCP Visits	$1000	80%	$500	$6350	D&C	D&C	$10 NSD/$25 SD/$75 SD/30% SD / Max $350
Ambetter Balanced Care 3	$2500	70%	$1000	$6350	$50 NSD	$75 NSD	$20 NSD/$50 SD/$100 SD/D&C / Max $350
Ambetter Balanced Care 4	$2000 INT	80%	INT	$6350	$50 NSD	$75 NSD	$20 NSD/$50 NSD/$100 SD/D&C
Ambetter Balanced Care 5	$3000	100%	$1000	$6350	$50 NSD	$75 NSD	$10 NSD/$50 SD/$75 SD/$250 SD
Ambetter Balanced Care 1	$5000	70%	$750	$6350	$25 NSD	$50 NSD	$10 NSD/$60 SD/50% SD/50% SD
Ambetter Balanced Care 2	$5000 INT	100%	INT	$5000	$30 NSD	$60 NSD	$10 NSD/$50 NSD/D&C/D&C
Ambetter Essential Care 2	$5000 INT	60%	INT	$6500	D&C	D&C	$25 NSD/$50 SD/$100 SD/D&C
Ambetter Essential Care 1	$6500 INT	100%	INT	$6500	D&C	D&C	$20 NSD/D&C/D&C/D&C
Ambetter Essential Care 3 with 3 Free PCP Visits	$6000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$50 SD/$100 SD/30% SD / Max $350
Ambetter Essential Care 4 with 3 Free PCP Visits	$4000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$100 SD/$150 SD/30% SD / Max $350

D&C – Deductible and Coinsurance

INT – Integrated Medical and Rx Deductible

NSD – Not subject to deductible

SD – Subject to deductible

Rx Copay – Generic / Preferred Brand / Non-Preferred Brand / Specialty

24.2. Current Rates

The current rates are attached in the form of the 2014 Federal Rate Template. Premiums are collected only on a monthly basis. The current rates do not change during the rating period. The current geographic rating factors are consistent with the expected unit cost differences between areas. The current rates are charged on an individual basis. For family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Affordable Care Act. The policyholder's premium payment under the current rates is impacted by the following factors:

- Geography
- Tobacco
- Age
- Plan Design

24.3. Proposed Rates

The proposed rates are attached in the form of the 2015 Federal Rate Template. Premiums will be collected only on a monthly basis. The proposed rates do not change during the rating period. The geographic factors are developed based upon contractual reimbursement differences and expected utilization differences in each of the established rating areas. Based upon the expected distribution of enrollment by area, the geographic factors reflect the single risk pool results consistent with the URRT. The geographic factors for unit cost and utilization differences within the manual rate model vary by Metropolitan Service Area (MSA), and are a component to the geographic factor. To the extent the established rating area is a subset of an MSA, the manual rate model geographic factors are supplemented with county specific unit cost relativities. The attached rate schedule is reflective of the geographic rating factors. The proposed rates are charged on an individual basis. For family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Affordable Care Act. The policyholder's premium payment under the current rates is impacted by the following factors:

- Geography
- Tobacco
- Age
- Plan Design

The policyholder's premium payment under the proposed rates is not impacted by changes in morbidity, additional mandates, or other factors.

24.4. Projected Experience with Requested Rate Change
Appendix K.1 demonstrates the projected experience with the requested rate change.

24.5. Projected Experience without Requested Rate Change
Appendix K.2 demonstrates the projected experience without the requested rate change.

24.6. Assumptions
The annual per individual rate of medical cost increase assumed for the next year is equal to 3.1%. The annual per individual rate of premium increase assumed for the next year is equal to -7.8%.

24.7. Premium Guarantee Provision
The proposed rates are guaranteed not to change through December 31, 2015.

24.8. Rating Factors
In accordance with the Affordable Care Act, rates may vary by age, geographic area, tobacco use and benefit plan. Rates are charged on an individual basis. For family coverage, rates for children are charged for no more than the three oldest covered children under age 21. Appendix B includes the base rate and allowable rating factors.

Administrative Expense Load: Based on our membership projections, we have projected that we need $49.13 PMPM to cover administrative expenses. This allowance is estimated to appropriately cover expenses for overhead, operations, sales, distribution, and marketing expenses.

We have estimated an additional $1.88 PMPM to cover approved quality improvement expenses and $2.00 PMPM to cover provider incentive payments.

The administrative expenses are allocated proportionally by plan.

Profit (or Contribution to Surplus) & Risk Margin: The proposed rates reflect 5.00% of premium as a risk/profit margin. This load was applied to all products and plans.

The following taxes and fees are included in the non-benefit expenses:

$2.00 Per Member Per Year for the Patient Centered Outcomes Research Fee (0.04% of Premium)
$1.00 Per Member Per Year for the Risk Adjustment User Fee (0.02% of Premium)
3.00% of premium for the Health Insurance Provider Fee
1.30% of premium for State of Indiana Premium Tax assessments
3.50% of premium for Federally Facilitated Exchange fee
0.40% of premium for anticipated assessments (high risk pool)

The Federal transitional reinsurance contribution of $3.67 PMPM is netted out of the reinsurance recoverable, as described in the previous section. It is not included as a non-benefit expense.

The impact of contractual agreements with health care providers and administrators is factored into the geographic area factors.

24.9. Historical Experience

Note that the products to which this rate filing applies were initially offered effective 1/1/2014. As a result, experience data is limited. The following table reflects the available membership and premium data available, through 2/28/2014.

Month	Membership	Premium Revenue
1/2014	179	$90,721
2/2014	251	$126,860

24.10. Projection of Lifetime Target Loss Ratio

The target loss ratio is projected over the next five years and beyond in the exhibit, 'Projection of Lifetime Target Loss Ratio'. Note that experience period data is not available due to the current benefits being offered for the first time on 1/1/2014. The first policy year refers to 2015. Note that proposed rates are resubmitted each year, so the actual expected future lifetime of the policies affected is only one year.

24.11. Company Financial Position

See Appendix I for documents summarizing the capital and surplus position of Coordinated Care Corporation.

25. Reliance

In the preparation of this filing, I relied upon data provided under the direction of Charles Kearns, Centene. I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

See Appendix J for a listing of items received for the rate development.

26. Actuarial Certification

I, Jason T. Nowakowski, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This filing is prepared on behalf of Coordinated Care Corporation (the "Company") to comply with applicable State and Federal Statutes for Individual Rate Filings.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I certify that this filing has been prepared in accordance with the following:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

I certify that the projected Index Rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Actuarially sound and developed in compliance with the applicable Actuarial Standards of Practice. For the purposes of this certification, actuarially sound is defined as, in consideration of expected reinsurance cash flows, risk adjustment cash flows, and investment income, containing adequate provision for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the essential health benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans. The AV Metal Values included in Worksheet 2 in Part I URRT were based on the Federal AV Calculator.

I certify that rates are charged to no more than the three oldest covered children under 21 for a family coverage.

I certify that, to the best of my knowledge and understanding, the proposed rates are in compliance with requirements under 45 CFR Subpart E (Section 156.400 through 156.470) and Coordinated Care Corporation intends to use the methodology outlined by HHS for advanced Cost-Sharing Reduction payments.

The Part I URRT does not demonstrate the process used by Coordinated Care Corporation to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

I certify that this rate filing was prepared in compliance with all applicable state and federal statutes and regulations.

I certify that this rate filing was prepared in compliance with Actuarial Standards of Practice (ASOP).

Signed: Jason T. Nowakowski

Name: Jason T. Nowakowski

Title: Principal & Consulting Actuary

Date: August 19, 2014

Appendix A
Coordinated Care Corporation
Age and Rating Area Distributions

Age Band	Percent Distribution
0-20	7.24%
21	1.44%
22	1.44%
23	1.44%
24	1.44%
25	2.08%
26	2.08%
27	2.08%
28	2.08%
29	2.08%
30	2.07%
31	2.07%
32	2.07%
33	2.07%
34	2.07%
35	2.16%
36	2.16%
37	2.16%
38	2.16%
39	2.16%
40	2.24%
41	2.24%
42	2.24%
43	2.24%
44	2.24%
45	2.21%
46	2.21%
47	2.21%
48	2.21%
49	2.21%
50	2.00%
51	2.00%
52	2.00%
53	2.00%
54	2.00%
55	2.49%
56	2.49%
57	2.49%
58	2.49%
59	2.49%
60	2.15%
61	2.15%
62	2.15%
63	2.15%
64	2.15%
65 and Over	0.00%

Rating Area	Percent Distribution
Rating Area 1	15.5%
Rating Area 2	8.7%
Rating Area 3	6.9%
Rating Area 4	8.6%
Rating Area 6	2.8%
Rating Area 10	39.7%
Rating Area 11	7.8%
Rating Area 13	3.4%
Rating Area 15	3.2%
Rating Area 16	3.3%

Appendix B
Coordinated Care Corporation
Rate Table

Base Rate	$265.50

Product Adjustment	
Product	PMPM Adj
35065IN001 (Appies to all plans)	$0.00
35065IN002 (Appies to all plans)	$4.66
35065IN003 (Appies to all plans)	$16.34

Plan	Rate Factor
Ambetter Secure Care 2	1.176
Ambetter Secure Care 1 with 3 Free PCP Visits	1.163
Ambetter Balanced Care 3	0.997
Ambetter Balanced Care 4	0.973
Ambetter Balanced Care 5	1.000
Ambetter Balanced Care 1	0.962
Ambetter Balanced Care 2	0.922
Ambetter Essential Care 2	0.771
Ambetter Essential Care 1	0.760
Ambetter Essential Care 3 with 3 Free PCP Visits	0.774
Ambetter Essential Care 4 with 3 Free PCP Visits	0.807

Age Band	Age Factor	Tobacco Factors	
		Smoker	Non-Smoker
0-20	0.635	1.155	1.000
21	1.000	1.155	1.000
22	1.000	1.155	1.000
23	1.000	1.155	1.000
24	1.000	1.155	1.000
25	1.004	1.085	1.000
26	1.024	1.085	1.000
27	1.048	1.085	1.000
28	1.087	1.085	1.000
29	1.119	1.085	1.000
30	1.135	1.085	1.000
31	1.159	1.085	1.000
32	1.183	1.085	1.000
33	1.198	1.085	1.000
34	1.214	1.085	1.000
35	1.222	1.055	1.000
36	1.230	1.055	1.000
37	1.238	1.055	1.000
38	1.246	1.055	1.000
39	1.262	1.055	1.000
40	1.278	1.102	1.000
41	1.302	1.132	1.000
42	1.325	1.162	1.000
43	1.357	1.192	1.000
44	1.397	1.222	1.000
45	1.444	1.172	1.000
46	1.500	1.212	1.000
47	1.563	1.252	1.000
48	1.635	1.292	1.000
49	1.706	1.332	1.000
50	1.786	1.455	1.000
51	1.865	1.415	1.000
52	1.952	1.375	1.000
53	2.040	1.335	1.000
54	2.135	1.295	1.000
55	2.230	1.250	1.000
56	2.333	1.225	1.000
57	2.437	1.200	1.000
58	2.548	1.175	1.000
59	2.603	1.150	1.000
60	2.714	1.120	1.000
61	2.810	1.105	1.000
62	2.873	1.090	1.000
63	2.952	1.075	1.000
64	3.000	1.060	1.000
65 and Over	3.000	1.060	1.000

Geographic Factors	
Area	Rate Factor
Rating Area 1	0.946
Rating Area 2	1.099
Rating Area 3	0.910
Rating Area 4	0.879
Rating Area 6	0.971
Rating Area 10	1.051
Rating Area 11	1.092
Rating Area 13	1.196
Rating Area 15	0.859
Rating Area 16	0.631

Appendix B
Coordinated Care Corporation
Rating Example

Family Rating Example

Plan Design:	Ambetter Secure Care 2
Product:	35065IN001

Member	**Age**	**Smoking Status**	**Rating Area**	(a) **Base**	(b) **Prod. Adj.**	(c) **Plan Rate Factor**	(d) = ((a) + (b)) x (c) **(Base + Prod. Adj.) * Plan Factor**	(e) **Age Factor**	(f) **Tobacco**	(g) **Area**	(h) = (d) x (e) x (f) x (g) **Final Premium**
Subscriber	40	Non-Smoker	Rating Area 1	$265.50	$0.00	1.176	$312.23	1.278	1.000	0.946	$377.48
Spouse	38	Non-Smoker	Rating Area 1	265.50	0.00	1.176	312.23	1.246	1.000	0.946	368.03
Child 1	18	Non-Smoker	Rating Area 1	265.50	0.00	1.176	312.23	0.635	1.000	0.946	187.56
Child 2	16	Non-Smoker	Rating Area 1	265.50	0.00	1.176	312.23	0.635	1.000	0.946	187.56
Child 3	14	Non-Smoker	Rating Area 1	265.50	0.00	1.176	312.23	0.635	1.000	0.946	187.56
Child 4	11	Non-Smoker	Rating Area 1	265.50	0.00	1.176	312.23	0.000	1.000	0.946	0.00
Total											**$1,308.18**

(1) Look up the plan rate factor based on the plan design.
(2) Multiply the plan's base rate by the plan rate factor.
(3) Look up the age factors for each member based on age.
Note that premiums can only be charged for the first 3 children, so the age factor for all subsequent children will be 0.
(4) Look up the tobacco factor for each member according to smoking status and age.
(5) Look up the area factor based on the rating area.
(6) Multiply the Consumer Adjusted Premium Rate by the age, tobacco and area factors for each member individually.
(7) Sum the results from (6) for the final premium for the family.

Appendix C
Coordinated Care Corporation
Benefit Category Mapping

MCRM Benefit Category	URRT Benefit Category
Inpatient Facility - Non-Maternity	
Medical	Inpatient Hospital
Medical - Other Newborn	Inpatient Hospital
Surgical	Inpatient Hospital
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Inpatient Facility - Maternity	
Deliveries	Inpatient Hospital
Non-Deliveries	Inpatient Hospital
Skilled Nursing Facility	Inpatient Hospital
Outpatient Facility	
Emergency Room	Outpatient Hospital
Surgery	Outpatient Hospital
Radiology	
Radiology - General	Outpatient Hospital
Radiology - CT / MRI / PET	Outpatient Hospital
Pathology/Lab	Outpatient Hospital
Pharmacy	Outpatient Hospital
Cardiovascular	Outpatient Hospital
PT/OT/ST	Outpatient Hospital
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Preventive	Outpatient Hospital
Other Outpatient Facility	Outpatient Hospital
Professional	
Inpatient Surgery - Non-Maternity	
Surgeon	Professional
Anesthesia	Professional
Maternity	
Non-Anesthesia	Professional
Anesthesia	Professional
Outpatient Surgery	
Outpatient Facility	Professional
Office	Professional
Anesthesia	Professional
Inpatient Visits	
Medical	Professional
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Office Visits & Miscellaneous Services	
Office/Home Visits	Professional
Urgent Care Visits	Professional
Office Administered Drugs	Professional
Allergy Testing	Professional

Appendix C
Coordinated Care Corporation
Benefit Category Mapping

MCRM Benefit Category	URRT Benefit Category
Allergy Immunotherapy	Professional
Miscellaneous Medical	Professional
Preventive Services	
Immunizations	Professional
Well Baby Exams	Professional
Physical Exams	Professional
Other Preventive	Professional
Other Professional Services	
ER Visits and Observation Care	Professional
Consults	Professional
Vision Exams	Professional
Hearing and Speech Exams	Professional
Physical Therapy	Professional
Cardiovascular	Professional
Radiology	
Inpatient	Professional
Outpatient	
Outpatient - General	Professional
Outpatient - CT / MRI / PET	Professional
Office	
Office - General	Professional
Office - CT / MRI / PET	Professional
Pathology/Lab	
Inpatient & Outpatient	Professional
Office	Professional
Chiropractor	Professional
Outpatient Psychiatric	Capitation
Outpatient Alcohol & Drug Abuse	Capitation
Other	
Prescription Drugs	Prescription Drug
Private Duty Nursing/Home Health	Other Medical
Ambulance	Other Medical
DME and Supplies	Other Medical
Prosthetics	Other Medical
OptiCare - Child - Exam / Hardware	Capitation
OptiCare - Child - Med / Surg	Capitation
OptiCare - Adult - Med / Surg	Capitation
Cenpatico	Capitation
Nurtur	Capitation
Nursewise	Capitation
Teladoc	Capitation
Start Smart	Capitation
Acupuncture	Professional
Habilitation Services	Professional

Appendix D
Coordinated Care Corporation
Development of Paid to Allowed Ratio

Product	Plan Name	PlanID	(a) Member Months	(b) Allowed Claims PMPM	(c) Paid Claims PMPM	(d) = (c) / (b) Paid to Allowed Ratio
		Aggregate	**147,869**	**$499.68**	**$350.76**	**0.702**
Ambetter	Ambetter Secure Care 2	35065IN0010002	1,472	$519.41	$421.98	0.812
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	490	524.11	416.42	0.795
Ambetter	Ambetter Balanced Care 3	35065IN0010007	2,366	501.11	372.31	0.743
Ambetter	Ambetter Balanced Care 4	35065IN0010008	8,307	492.46	350.73	0.712
Ambetter	Ambetter Balanced Care 5	35065IN0010009	7,099	498.70	371.65	0.745
Ambetter	Ambetter Balanced Care 1	35065IN0010015	11,076	503.00	369.04	0.734
Ambetter	Ambetter Balanced Care 2	35065IN0010014	18,473	507.67	347.46	0.684
Ambetter	Ambetter Essential Care 2	35065IN0010016	3,686	437.84	269.59	0.616
Ambetter	Ambetter Essential Care 1	35065IN0010017	5,898	442.84	265.64	0.600
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	3,686	438.92	270.77	0.617
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	1,474	444.72	281.80	0.634
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	264	$525.01	$427.58	0.814
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	88	529.71	422.02	0.797
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	551	506.67	377.87	0.746
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	1,794	498.02	356.29	0.715
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	1,651	504.26	377.21	0.748
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	2,667	508.55	374.59	0.737
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	4,341	513.21	353.01	0.688
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	749	443.37	275.12	0.621
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	1,199	448.37	271.18	0.605
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	749	444.45	276.30	0.622
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	300	450.26	287.33	0.638
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1,181	$539.90	$442.47	0.820
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	394	544.59	436.90	0.802
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	2,692	521.46	392.65	0.753
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	8,571	512.81	371.08	0.724
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	8,079	519.05	391.99	0.755
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	13,199	523.32	389.36	0.744
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	21,325	527.97	367.77	0.697
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	3,512	458.10	289.84	0.633
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	5,619	463.09	285.89	0.617
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	3,512	459.17	291.02	0.634
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	1,405	464.99	302.07	0.650

Appendix E
Coordinated Care Corporation
Index Rate to Base Rate

			Notes
(a)	**Projected Index Rate PMPM**	$489.59	Total EHB Allowed Charges (Index Rate)
	Market Adjustments		
(b)	Net Risk Adjustment Transfer Paid/(Received)	($25.44)	Includes Risk Adjustment Admin Fee.
(c)	Net Transitional Reinsurance Payment/(Received)	(23.07)	Total composite reinsurance impact on claims, net of reinsurance premium ($3.67).
(d)	Exchange User Fees	13.87	
(e) = (a) + .. + (d)	**Market Adjusted Index Rate**	$454.95	
	Plan Adjustments		
(f)	Member Cost Sharing	($83.22)	
(g)	Silver Plan Cost Sharing Reduction Subsidy	(65.70)	
(h)	SG&A	51.71	
(i)	Profit Margin	12.11	Assumption: 5% profit margin before Federal and State Income Taxes. This does not include the $0.38 profit margin on buy-ups.
(j)	Licensing, Taxes and Fees	26.51	
(k)	Other Benefits Common to All Plans	-	
(l) = (e) + ... + (k)	**Index Rate before Plan Factor Adjustment**	$396.36	

Plan ID	Plan Name	*(1)* Member Months	*(2) = (l)* Index Rate before Plan Factor Adj	*(3)* Actuarial Value and Cost Sharing Adjustment	*(4)* Non-EHB Adjustment (1)	*(5)* Tobacco Surcharge	*(6) = (2) * (3) * (4) * (5)* Plan Adjusted Index Rate	*(7) = (t)* Calibration	*(8) = (6) / (7)* Plan Adjusted Index Rate Divided by Calibration
35065IN0010002	Ambetter Secure Care 2	1,472	$396.36	1.276	1.000	0.987	$499.15	1.599	$312.16
35065IN0010004	Ambetter Secure Care 1 with 3 Free PCP Visits	490	396.36	1.262	1.000	0.987	493.81	1.599	308.83
35065IN0010007	Ambetter Balanced Care 3	2,366	396.36	1.082	1.000	0.987	423.29	1.599	264.73
35065IN0010008	Ambetter Balanced Care 4	8,307	396.36	1.055	1.000	0.987	412.93	1.599	258.25
35065IN0010009	Ambetter Balanced Care 5	7,099	396.36	1.085	1.000	0.987	424.54	1.599	265.50
35065IN0010015	Ambetter Balanced Care 1	11,076	396.36	1.044	1.000	0.987	408.54	1.599	255.50
35065IN0010014	Ambetter Balanced Care 2	18,473	396.36	1.001	1.000	0.987	391.49	1.599	244.84
35065IN0010016	Ambetter Essential Care 2	3,686	396.36	0.837	1.000	0.987	327.36	1.599	204.73
35065IN0010017	Ambetter Essential Care 1	5,898	396.36	0.825	1.000	0.987	322.71	1.599	201.82
35065IN0010012	Ambetter Essential Care 3 with 3 Free PCP Visits	3,686	396.36	0.840	1.000	0.987	328.80	1.599	205.63
35065IN0010013	Ambetter Essential Care 4 with 3 Free PCP Visits	1,474	396.36	0.875	1.000	0.987	342.42	1.599	214.15
35065IN0020002	Ambetter Secure Care 2 + Vision	264	396.36	1.276	1.018	0.987	507.90	1.599	317.64
35065IN0020004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	88	396.36	1.262	1.018	0.987	502.47	1.599	314.24
35065IN0020007	Ambetter Balanced Care 3 + Vision	551	396.36	1.082	1.018	0.987	430.72	1.599	269.37
35065IN0020008	Ambetter Balanced Care 4 + Vision	1,794	396.36	1.055	1.018	0.987	420.18	1.599	262.78
35065IN0020009	Ambetter Balanced Care 5 + Vision	1,651	396.36	1.085	1.018	0.987	431.98	1.599	270.16
35065IN0020015	Ambetter Balanced Care 1 + Vision	2,667	396.36	1.044	1.018	0.987	415.70	1.599	259.98
35065IN0020014	Ambetter Balanced Care 2 + Vision	4,341	396.36	1.001	1.018	0.987	398.36	1.599	249.13
35065IN0020016	Ambetter Essential Care 2 + Vision	749	396.36	0.837	1.018	0.987	333.10	1.599	208.32
35065IN0020017	Ambetter Essential Care 1 + Vision	1,199	396.36	0.825	1.018	0.987	328.37	1.599	205.36
35065IN0020012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	749	396.36	0.840	1.018	0.987	334.57	1.599	209.24
35065IN0020013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	300	396.36	0.875	1.018	0.987	348.42	1.599	217.90
35065IN0030002	Ambetter Secure Care 2 + Vision + Adult Dental	1,181	396.36	1.276	1.062	0.987	529.86	1.599	331.37
35065IN0030004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	394	396.36	1.262	1.062	0.987	524.19	1.599	327.83
35065IN0030007	Ambetter Balanced Care 3 + Vision + Adult Dental	2,692	396.36	1.082	1.062	0.987	449.34	1.599	281.01
35065IN0030008	Ambetter Balanced Care 4 + Vision + Adult Dental	8,571	396.36	1.055	1.062	0.987	438.34	1.599	274.14
35065IN0030009	Ambetter Balanced Care 5 + Vision + Adult Dental	8,079	396.36	1.085	1.062	0.987	450.66	1.599	281.84
35065IN0030015	Ambetter Balanced Care 1 + Vision + Adult Dental	13,199	396.36	1.044	1.062	0.987	433.67	1.599	271.22
35065IN0030014	Ambetter Balanced Care 2 + Vision + Adult Dental	21,325	396.36	1.001	1.062	0.987	415.58	1.599	259.90
35065IN0030016	Ambetter Essential Care 2 + Vision + Adult Dental	3,512	396.36	0.837	1.062	0.987	347.50	1.599	217.33
35065IN0030017	Ambetter Essential Care 1 + Vision + Adult Dental	5,619	396.36	0.825	1.062	0.987	342.57	1.599	214.24
35065IN0030012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	3,512	396.36	0.840	1.062	0.987	349.03	1.599	218.28
35065IN0030013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	1,405	396.36	0.875	1.062	0.987	363.49	1.599	227.32
Total		147,869	$396.36	1.000	1.031	0.987	$403.28	1.599	$252.21

(m) = (8)	Consumer Adjusted Index Rate	$252.21	
(n)	Composite Plan Factor	0.950	
(o)	Interaction (2)	1.000	
(p) = ((m) / (n)) * (o)	**Base Rate (= Appendix B.1 "Base Rate")**	$265.50	
	Calibration		
(q)	Composite Area Factor	1.000	
(r)	Composite Age Factor	1.598	The weighted average age is 47.
(s)	Interaction (3)	1.000	
(t) = (q) * (r) * (s)	**Calibration**	1.599	

Notes:
(1) Non-EHB Adjustment includes impacts to SG&A and profit margin due to offering Adult Vision.
(2) The interaction term accounts for the interdependence of the tobacco and plan factors (EHB and Non-EHB).
(3) The interaction term accounts for the interdependence of the area, age, tobacco and plan factors.

Appendix F
Coordinated Care Corporation
AV Calculator Results

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.3%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.88%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	70.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.87%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$150.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	95.00%	70.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$2.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$5.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.46%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.67%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.85%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.90%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$100.00			
Coinsurance (%, Insurer's Cost Share)			95.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☐	☐		$5.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.79%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$250.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$150.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.2%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$10.00	☑	☑		
Skilled Nursing Facility	☑	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	97%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.97%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$25.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	97%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$100.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$750.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.49%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$1,750.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%	
OOP Maximum ($)	$5,200.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.90%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$150.00	$150.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%	
OOP Maximum ($)	$2,250.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.81%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$750.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.77%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$5,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.65%
Metal Tier:	Silver

Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.75%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☑		$1.00	☑	☑		
Preferred Brand Drugs	☐	☑		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.65%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.81%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.89%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.24%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.57%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$150.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.64%
Metal Tier:	Bronze

Appendix G
Coordinated Care Corporation
AV Pricing Value Allocation

Product	Plan Name	PlanID	Pricing AV	Provider Network, Delivery System and Utilization Management	Actuarial Value and Cost Sharing Adjustment	Non-EHB Benefits	Tobacco Surcharge	Administrative Cost
Ambetter	Ambetter Secure Care 2	35065IN0010002	1.097	1.000	0.858	1.000	0.987	1.295
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	1.085	1.000	0.849	1.000	0.987	1.295
Ambetter	Ambetter Balanced Care 3	35065IN0010007	0.930	1.000	0.728	1.000	0.987	1.295
Ambetter	Ambetter Balanced Care 4	35065IN0010008	0.908	1.000	0.710	1.000	0.987	1.295
Ambetter	Ambetter Balanced Care 5	35065IN0010009	0.933	1.000	0.730	1.000	0.987	1.295
Ambetter	Ambetter Balanced Care 1	35065IN0010015	0.898	1.000	0.702	1.000	0.987	1.295
Ambetter	Ambetter Balanced Care 2	35065IN0010014	0.861	1.000	0.673	1.000	0.987	1.295
Ambetter	Ambetter Essential Care 2	35065IN0010016	0.720	1.000	0.563	1.000	0.987	1.295
Ambetter	Ambetter Essential Care 1	35065IN0010017	0.709	1.000	0.555	1.000	0.987	1.295
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	0.723	1.000	0.565	1.000	0.987	1.295
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	0.753	1.000	0.589	1.000	0.987	1.295
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	1.116	1.000	0.858	1.018	0.987	1.295
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	1.104	1.000	0.849	1.018	0.987	1.295
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	0.947	1.000	0.728	1.018	0.987	1.295
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	0.924	1.000	0.710	1.018	0.987	1.295
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	0.950	1.000	0.730	1.018	0.987	1.295
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	0.914	1.000	0.702	1.018	0.987	1.295
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	0.876	1.000	0.673	1.018	0.987	1.295
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	0.732	1.000	0.563	1.018	0.987	1.295
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	0.722	1.000	0.555	1.018	0.987	1.295
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	0.735	1.000	0.565	1.018	0.987	1.295
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	0.766	1.000	0.589	1.018	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1.165	1.000	0.858	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	1.152	1.000	0.849	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	0.988	1.000	0.728	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	0.963	1.000	0.710	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	0.991	1.000	0.730	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	0.953	1.000	0.702	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	0.913	1.000	0.673	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	0.764	1.000	0.563	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	0.753	1.000	0.555	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	0.767	1.000	0.565	1.062	0.987	1.295
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	0.799	1.000	0.589	1.062	0.987	1.295

Appendix H
Coordinated Care Corporation
Membership Projections

			Member Months						
				Silver Plan					
Product	**Plan Name**	**Plan ID**	**Gold**	**70%**	**73%**	**87%**	**94%**	**Bronze**	**Total**
		Aggregate	**3,889**	**12,966**	**11,240**	**39,246**	**48,739**	**31,789**	**147,869**
Ambetter	Ambetter Secure Care 2	35065IN0010002	1,472	-	-	-	-	-	1,472
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	490	-	-	-	-	-	490
Ambetter	Ambetter Balanced Care 3	35065IN0010007	-	328	278	785	975	-	2,366
Ambetter	Ambetter Balanced Care 4	35065IN0010008	-	1,969	2,224	3,139	975	-	8,307
Ambetter	Ambetter Balanced Care 5	35065IN0010009	-	985	834	2,355	2,925	-	7,099
Ambetter	Ambetter Balanced Care 1	35065IN0010015	-	657	834	4,710	4,875	-	11,076
Ambetter	Ambetter Balanced Care 2	35065IN0010014	-	2,626	1,390	4,710	9,747	-	18,473
Ambetter	Ambetter Essential Care 2	35065IN0010016	-	-	-	-	-	3,686	3,686
Ambetter	Ambetter Essential Care 1	35065IN0010017	-	-	-	-	-	5,898	5,898
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	-	-	-	-	-	3,686	3,686
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	-	-	-	-	-	1,474	1,474
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	264	-	-	-	-	-	264
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	88	-	-	-	-	-	88
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	-	59	52	196	244	-	551
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	-	352	413	785	244	-	1,794
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	-	176	155	589	731	-	1,651
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	-	117	155	1,177	1,218	-	2,667
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	-	469	258	1,177	2,437	-	4,341
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	-	-	-	-	-	749	749
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	-	-	-	-	-	1,199	1,199
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	-	-	-	-	-	749	749
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	-	-	-	-	-	300	300
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1,181	-	-	-	-	-	1,181
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	394	-	-	-	-	-	394
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	-	261	232	981	1,218	-	2,692
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	-	1,569	1,859	3,925	1,218	-	8,571
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	-	784	697	2,943	3,655	-	8,079
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	-	523	697	5,887	6,092	-	13,199
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	-	2,091	1,162	5,887	12,185	-	21,325
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	-	-	-	-	-	3,512	3,512
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	-	-	-	-	-	5,619	5,619
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	-	-	-	-	-	3,512	3,512
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	-	-	-	-	-	1,405	1,405

Appendix I
Coordinated Care Corporation
Capital, Surplus and RBC

ASSETS

	Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1. Bonds (Schedule D)	71,141,230		71,141,230	42,130,488
2. Stocks (Schedule D):				
2.1 Preferred stocks	0		0	0
2.2 Common stocks	10,013,713		10,013,713	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5. Cash ($ 43,301,901 , Schedule E-Part 1), cash equivalents ($ 0 , Schedule E-Part 2) and short-term investments ($ 44,427,016 , Schedule DA)	87,728,917		87,728,917	88,176,976
6. Contract loans (including $ ..... premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)	1,653,392		1,653,392	1,299,177
9. Receivables for securities			0	5,000
10. Securities lending reinvested collateral assets (Schedule DL)			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	170,537,252	0	170,537,252	131,611,641
13. Title plants less $ ..... charged off (for Title insurers only)			0	0
14. Investment income due and accrued	473,403		473,403	464,665
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	4,882,895		4,882,895	11,897,969
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums			0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	1,209,054		1,209,054	745,177
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans			0	0
18.1 Current federal and foreign income tax recoverable and interest thereon			0	0
18.2 Net deferred tax asset	5,403,936		5,403,936	3,710,600
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software			0	0
21. Furniture and equipment, including health care delivery assets ($ .....)			0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	2,392		2,392	67,257
24. Health care ($ 106,095) and other amounts receivable	809,520	703,425	106,095	41,976
25. Aggregate write-ins for other than invested assets	5,778,278	122,933	5,655,345	5,553,078
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	189,096,730	826,358	188,270,372	154,092,363
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	189,096,730	826,358	188,270,372	154,092,363
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. Prepaid Expenses	122,933	122,933	0	0
2502. Company-owned life insurance	5,346,469		5,346,469	5,223,255
2503. State Income tax receivable	308,876		308,876	329,823
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	5,778,278	122,933	5,655,345	5,553,078

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	Current Year 2 Uncovered	Current Year 3 Total	Prior Year 4 Total
1. Claims unpaid (less $ 2,261,521 reinsurance ceded)	66,623,379		66,623,379	52,689,614
2. Accrued medical incentive pool and bonus amounts	6,726,935		6,726,935	2,946,531
3. Unpaid claims adjustment expenses	1,121,000		1,121,000	1,150,000
4. Aggregate health policy reserves, including the liability of $ for medical loss ratio rebate per the Public Health Service Act	8,164,161		8,164,161	4,679,976
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance	25,438,117		25,438,117	23,291,195
9. General expenses due or accrued	6,125,364		6,125,364	14,290,652
10.1 Current federal and foreign income tax payable and interest thereon (including $ on realized capital gains (losses))	3,151,891		3,151,891	3,937,398
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others			0	0
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ current) and interest thereon $ (including $ current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	776,471		776,471	142,708
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ authorized reinsurers, $ unauthorized reinsurers and $ certified reinsurers)			0	0
20. Reinsurance in unauthorized and certified ($) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ current)	13,045,633	0	13,045,633	7,742
24. Total liabilities (Lines 1 to 23)	131,172,951	0	131,172,951	103,135,816
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	545,000	545,000
27. Preferred capital stock	XXX	XXX		0
28. Gross paid in and contributed surplus	XXX	XXX	21,700,000	21,700,000
29. Surplus notes	XXX	XXX		0
30. Aggregate write-ins for other-than-special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	34,852,421	28,711,547
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 $)	XXX	XXX		0
32.2 shares preferred (value included in Line 27 $)	XXX	XXX		0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	57,097,421	50,956,547
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	188,270,372	154,092,363
DETAILS OF WRITE-INS				
2301. State Income Tax Payable			0	7,742
2302. Washington Premium Adjustment	13,045,633		13,045,633	
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	13,045,633	0	13,045,633	7,742
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	0	0

COORDINATED CARE CORPORATION

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		57,097,421	
(2)	Company Action Level = 200% of Authorized Control Level	CAL	35,961,746	
(3)	Regulatory Action Level = 150% of Authorized Control Level	RAL	26,971,310	
(4)	Authorized Control Level = 100% of Authorized Control Level	ACL	17,980,873	
(5)	Mandatory Control Level = 70% of Authorized Control Level	MCL	12,586,611	
(6)	Level of Action, if Any	NONE		

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	57,097,421
Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page	17,980,873

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	569,967,437	
(8)	Underwriting Deductions	Page 4, Line 23	561,641,756	
(9)	Combined Ratio	Line (8)/Line (7)	98.539	
(10)	RBC Ratio	Line (1)/Line (4)	317.545	
(11)	Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then “Yes”, otherwise “No”		NO
(12)	Level of Action, if any, including Trend Test		NONE	

Appendix J
Coordinated Care Corporation
Data and Assumption Reliance for 2015 Individual Exchange Premium Development

Data / Assumption	Source
2015 Individual Exchange Enrollment	Charles Kearns, Centene
2015 Individual Exchange Market Share, by county and income bracket	Charles Kearns, Centene
2015 Individual Exchange Attrition, Market Share, and Buy-Ups (by FPL) Assumptions	Charles Kearns, Centene
Aggregate health insurance coverage transition rates, 2011-2014	SOA/Optum ("Cost of the Future Newly Insured under the Affordable Care Act (ACA)")
Pricing and Premium Development Models	Milliman
Basic tables of utilization, cost, claims probability distributions, pricing adjustment factors, and primary care/specialty care utilization distribution	Milliman (Health Cost Guidelines)
Pre-ACA Large Group Claims Cost PMPM	CCIIO (2011 MLR)
Pre-ACA Large Group Actuarial Value	MarketScan (Commercial Claims Database)
Pre-ACA Large Group Unit Costs	MarketScan (Commercial Claims Database) and Billed Charge Discounts (CMS Medicare claims data)
Prospective Morbidity Factors by Health Status, Age, and Gender	US Census Bureau (2009-2011 Current Population Survey), Milliman (Small Group Medical Underwriting Guidelines)
Health insurance transition rate relativities by age, gender, income, and health status	Milliman
Pre-ACA health status distribution by age, income, and insurance coverage	US Census Bureau (2009-2011 Current Population Survey)
Pre-ACA enrollment counts for Individual, Small Group Fully Insured, and Large Group Fully Insured markets	CCIIO (2011 MLR Dataset)
Pre-ACA enrollment counts for Employer Group, Part-Time, Retiree, Medicaid/Other Public, Medicare/Dual, and Uninsured markets	US Census Bureau (2011 American Community Survey)
Distribution of pre-ACA enrollment by age, gender, and income bracket, within each insurance coverage category	US Census Bureau (2011 American Community Survey)
State and Federal High Risk Pool Enrollment	National Conference of State Legislatures ("High Risk Pools for Health Coverage, State and Federal (State Implementation Report)")
2015 Individual Exchange Benefit Designs	Charles Kearns, Centene
Centene pre-ACA enrollment, claims data, and benefit designs	Charles Kearns, Centene
Utilization trends	Milliman
Unit Cost trends	Charles Kearns, Centene
Anticipated Centene Individual Exchange Unit Costs	Centene Reimbursement Targets based on Medicare (CMS Medicare claims data) and Billed Charge Discounts (CMS Medicare claims data)
Administrative Costs, Taxes, and Fees	Charles Kearns, Centene
CCHP Delinquency Numbers	Charles Kearns, Centene
Subcapitated Contracts and Pricing	Charles Kearns, Centene
Value Added Benefits	Charles Kearns, Centene
Smoking Relativity Factors	Charles Kearns, Centene/Milliman
County Rating Areas	Charles Kearns, Centene
Centene Service Areas	Charles Kearns, Centene
Expected Reimbursement by Rating Area and State	Charles Kearns, Centene
OON Inpatient Services Utilization	Charles Kearns, Centene
Utilization Management	Charles Kearns, Centene
3:1 Age Band Factors	HHS
Prescription Drug Assumptions: AWP Discount, Dispensing Fee, Rebates, Retail/Mail Utilization percentages, formularies, and Rx Management Assumptions	US Scripts
Capital, Surplus, and RBC from Annual Statement	Charles Kearns, Centene

Appendix K
Coordinated Care Corporation
Projected Experience with and without Requested Rate Change

	With Requested Rate Change	Without Requested Rate Change
Enrollment Projection	147,869	147,869
Earned Premium		
Next 12 Months	$408.70	$443.16
Next Full Calendar Year	$408.70	$443.16
Anticipated Implementation Date (1)	$408.70	$443.16
Projected Incurred Claims		
Next 12 Months	$301.50	$301.50
Next Full Calendar Year	$301.50	$301.50
Anticipated Loss Ratio		
Next 12 Months	73.8%	68.0%
Next Full Calendar Year	73.8%	68.0%

(1) Anticipated implementation date is 1/1/2015.

2014 Names	2015 Names	2015 Vision Buy-up	2015 Vision and Dental Buy-up	Characters
Ambetter Gold 2	Ambetter Secure Care 2	Ambetter Secure Care 2 + Vision	Ambetter Secure Care 2 + Vision + Adult Dental	46
Ambetter Gold 4	Ambetter Secure Care 1 with 3 Free PCP Visits	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	69
Ambetter Silver 3	Ambetter Balanced Care 3	Ambetter Balanced Care 3 + Vision	Ambetter Balanced Care 3 + Vision + Adult Dental	48
Ambetter Silver 4	Ambetter Balanced Care 4	Ambetter Balanced Care 4 + Vision	Ambetter Balanced Care 4 + Vision + Adult Dental	48
Ambetter Silver 5	Ambetter Balanced Care 5	Ambetter Balanced Care 5 + Vision	Ambetter Balanced Care 5 + Vision + Adult Dental	48
NEW	Ambetter Balanced Care 2	Ambetter Balanced Care 2 + Vision	Ambetter Balanced Care 2 + Vision + Adult Dental	48
NEW	Ambetter Balanced Care 1	Ambetter Balanced Care 1 + Vision	Ambetter Balanced Care 1 + Vision + Adult Dental	48
Ambetter Bronze 3	Ambetter Essential Care 3 with 3 Free PCP Visits	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	72
Ambetter Bronze 4	Ambetter Essential Care 4 with 3 Free PCP Visits	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	72
NEW	Ambetter Essential Care 1	Ambetter Essential Care 1 + Vision	Ambetter Essential Care 1 + Vision + Adult Dental	49
NEW	Ambetter Essential Care 2	Ambetter Essential Care 2 + Vision	Ambetter Essential Care 2 + Vision + Adult Dental	49

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page	28 & 32 #3	of	61
Specialist Visit	See Page	32, #3	of	61
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page	32 #4	of	61
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page	32	of	61
Outpatient Surgery Physician/Surgical Services	See Page	32	of	61
Hospice Services	See Page	32	of	61
Private-Duty Nursing	See Page	31, #2	of	61
Urgent Care Centers or Facilities	See Page	34, #20	of	61
Home Health Care Services	See Page	31	of	61
Emergency Room Services	See Page	32, #1(f)	of	61
Emergency Transportation/Ambulance	See Page	29	of	61
Inpatient Hospital Services (e.g., Hospital Stay)	See Page	32, #1	of	61
Inpatient Physician and Surgical Services	See Page	32, #1(c)	of	61
Skilled Nursing Facility	See Page	30	of	61
Prenatal and Postnatal Care	See Page	33, #16	of	61
Delivery and All Inpatient Services for Maternity Care	See Page	33, #16	of	61
Mental/Behavioral Health Outpatient Services	See Page	30	of	61
Mental/Behavioral Health Inpatient Services	See Page	30	of	61
Substance Abuse Disorder Outpatient Services	See Page	30	of	61
Substance Abuse Disorder Inpatient Services	See Page	30	of	61
Generic Drugs	See Page	34	of	61
Preferred Brand Drugs	See Page	34	of	61
Non-Preferred Brand Drugs	See Page	34	of	61
Specialty Drugs	See Page	34	of	61
Outpatient Rehabilitation Services	See Page	30	of	61
Habilitation Services	See Page	30	of	61
Chiropractic Care	See Page	33	of	61
Durable Medical Equipment	See Page	31	of	61
Imaging (CT/PET Scans, MRIs)	See Page	34, #21	of	61
Preventive Care/Screening/Immunization	See Page	36	of	61

Routine Eye Exam for Children	See Page	35	of	61
Eye Glasses for Children	See Page	35	of	61
Dental Check-Up for Children	See Page	N/A	of	61
Rehabilitative Speech Therapy	See Page	20 & 30	of	61
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page	20 & 30	of	61
Well Baby Visits and Care	See Page	37	of	61
Laboratory Outpatient and Professional Services	See Page	33, #7	of	61
X-rays and Diagnostic Imaging	See Page	33, #7	of	61
Basic Dental Care – Child	See Page	N/A	of	
Orthodontia – Child	See Page	N/A	of	
Major Dental Care – Child	See Page	N/A	of	
Transplant	See Page	39	of	61
Accidental Dental	See Page	33, #12	of	61
Dialysis	See Page	33, #9	of	61
Allergy Testing	See Page	33, #22	of	61
Chemotherapy	See Page	33, #8	of	61
Radiation	See Page	33, #8	of	61
Diabetes Education	See Page	33, #15	of	61
Prosthetic Devices	See Page	33, #1	of	61
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Treatment for Temporomandibular Joint Disorders	See Page	33, #13	of	61
Nutritional Counseling	See Page	33	of	61
Reconstructive Surgery	See Page	33, #14	of	61
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Inherited Metabolic Disorder - PKU	See Page	37	of	61
Off Label Prescription Drugs	See Page	34, #4	of	61
Dental Anesthesia	See Page	36	of	61
Mental Health Other	See Page	29-30	of	61

I, on behalf of Centene Corporation hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by Coordinate Care Corporation for review and approval.

Michelle

Name: Compliance Analyst Title: 05/09/2014 Date:

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page	28 & 32 #3	of	62
Specialist Visit	See Page	32, #3	of	62
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page	32 #4	of	62
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page	32	of	62
Outpatient Surgery Physician/Surgical Services	See Page	32	of	62
Hospice Services	See Page	32	of	62
Private-Duty Nursing	See Page	31, #2	of	62
Urgent Care Centers or Facilities	See Page	34, #20	of	62
Home Health Care Services	See Page	31	of	62
Emergency Room Services	See Page	32, #1(f)	of	62
Emergency Transportation/Ambulance	See Page	29	of	62
Inpatient Hospital Services (e.g., Hospital Stay)	See Page	32, #1	of	62
Inpatient Physician and Surgical Services	See Page	32, #1(c)	of	62
Skilled Nursing Facility	See Page	30	of	62
Prenatal and Postnatal Care	See Page	33, #16	of	62
Delivery and All Inpatient Services for Maternity Care	See Page	33, #16	of	62
Mental/Behavioral Health Outpatient Services	See Page	30	of	62
Mental/Behavioral Health Inpatient Services	See Page	30	of	62
Substance Abuse Disorder Outpatient Services	See Page	30	of	62
Substance Abuse Disorder Inpatient Services	See Page	30	of	62
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Preferred Brand Drugs	See Page	34	of	62
Non-Preferred Brand Drugs	See Page	34	of	62
Specialty Drugs	See Page	34	of	62
Outpatient Rehabilitation Services	See Page	30	of	62
Habilitation Services	See Page	30	of	62
Chiropractic Care	See Page	33	of	62
Durable Medical Equipment	See Page	44	of	62
Imaging (CT/PET Scans, MRIs)	See Page	34, #21	of	62
Preventive Care/Screening/Immunization	See Page	37	of	62

Routine Eye Exam for Children	See Page	35	of	62
Eye Glasses for Children	See Page	35	of	62
Dental Check-Up for Children	See Page	N/A	of	62
Rehabilitative Speech Therapy	See Page	20 & 30	of	62
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page	20 & 30	of	62
Well Baby Visits and Care	See Page	38	of	62
Laboratory Outpatient and Professional Services	See Page	33, #7	of	62
X-rays and Diagnostic Imaging	See Page	33, #7	of	62
Basic Dental Care – Child	See Page	N/A	of	
Orthodontia – Child	See Page	N/A	of	
Major Dental Care – Child	See Page	N/A	of	
Transplant	See Page	40	of	62
Accidental Dental	See Page	33, #12	of	62
Dialysis	See Page	33, #9	of	62
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Prosthetic Devices	See Page	33, #1	of	62
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Nutritional Counseling	See Page	33	of	62
Reconstructive Surgery	See Page	33, #14	of	62
Clinical Trials	See Page	40	of	62
Diabetes Care Management	See Page	33, #15	of	62
Inherited Metabolic Disorder - PKU	See Page	38	of	62
Off Label Prescription Drugs	See Page	34, #4	of	62
Dental Anesthesia	See Page	37	of	62
Mental Health Other	See Page	29-30	of	62

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Name: Michelle

Title: Compliance Analyst

Date: 05/09/2014

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Specialty Drugs	See Page	34	of	63
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Chiropractic Care	See Page	33	of	63
Durable Medical Equipment	See Page	45	of	63
Imaging (CT/PET Scans, MRIs)	See Page	34, #21	of	63
Preventive Care/Screening/Immunization	See Page	38	of	63

Routine Eye Exam for Children	See Page	35	of	63
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Michelle

Name: Michelle

Title: Compliance Analyst

Date: 05/09/2014

ON/OFF EXCHANGE ATTESTATION

Ambetter from Coordinated Care Corporation, dba MHS

The undersigned hereby attests that the enclosed rates have been reviewed and that the same premium rate is being charged without regard to whether the plans are offered on the Exchange, or whether the plans are offered directly by Ambetter from Coordinated Care, dba MHS or through an agent.

PLAN	PLAN NAME
35065IN0010002	Ambetter Secure Care 2
35065IN0010004	Ambetter Secure Care 1 with 3 Free PCP Visits
35065IN0010007	Ambetter Balanced Care 3
35065IN0010008	Ambetter Balanced Care 4
35065IN0010009	Ambetter Balanced Care 5
35065IN0010014	Ambetter Balanced Care 2
35065IN0010015	Ambetter Balanced Care 1
35065IN0010012	Ambetter Essential Care 3 with 3 Free PCP Visits
35065IN0010013	Ambetter Essential Care 4 with 3 Free PCP Visits
35065IN0010016	Ambetter Essential Care 2
35065IN0010017	Ambetter Essential Care 2
35065IN0020002	Ambetter Secure Care 2 + Vision
35065IN0020004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision
35065IN0020007	Ambetter Balanced Care 3 + Vision
35065IN0020008	Ambetter Balanced Care 4 + Vision
35065IN0020009	Ambetter Balanced Care 5 + Vision
35065IN0020014	Ambetter Balanced Care 2 + Vision
35065IN0020015	Ambetter Balanced Care 1 + Vision
35065IN0020012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision
35065IN0020013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision
35065IN0020016	Ambetter Essential Care 2 + Vision
35065IN0020017	Ambetter Essential Care 1 + Vision
35065IN0030002	Ambetter Secure Care 2 + Vision + Adult Dental
35065IN0030004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental
35065IN0030007	Ambetter Balanced Care 3 + Vision + Adult Dental
35065IN0030008	Ambetter Balanced Care 4 + Vision + Adult Dental
35065IN0030009	Ambetter Balanced Care 5 + Vision + Adult Dental
35065IN0030014	Ambetter Balanced Care 2 + Vision + Adult Dental
35065IN0030015	Ambetter Balanced Care 1 + Vision + Adult Dental
35065IN0030012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental
35065IN0030013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental

35065IN0030016	Ambetter Essential Care 2 + Vision + Adult Dental
35065IN0030017	Ambetter Essential Care 1 + Vision + Adult Dental

By: _____
Signature

Name: Steele Stewart
Title: Vice President, Actuarial Services & Risk Management
Date: May 9, 2014

CERTIFICATE OF READABILITY

Ambetter from Coordinated Care Corporation, dba MHS

The undersigned hereby certifies that the enclosed form(s) have been reviewed and that to the best of my knowledge and belief the form(s) meet(s) the minimum Flesch reading ease score requirement of 40.

FORM NUMBER	FORM NAME
35065IN0001	HMO Evidence of Coverage
35065IN0002	HMO Evidence of Coverage
35065IN0003	HMO Evidence of Coverage

By:_____
Signature

Name: Daniel Martinez
Title: Regional Manager, Compliance and Regulatory Affairs
Date: May 9, 2014

OFF EXCHANGE APTC ATTESTATION

Ambetter from Coordinated Care Corporation, dba MHS

The undersigned hereby attests that if any plans offered by *Ambetter from Coordinated Care, dba M*HS are purchased off the exchange then the member/consumer will not be eligible for a Premium Tax Credit.

By:_____
Signature

Name: Steele Stewart
Title: Vice President, Actuarial Services & Risk Management
Date: May 9, 2014

OFF EXCHANGE APTC DISCLOSURE

Ambetter from Coordinated Care Corporation, dba MHS

Should you choose to purchase this plan, offered by *Ambetter from Coordinated Care dba MHS,* off the exchange you will not be eligible to receive a Premium Tax Credit. Any plans purchased off the exchange are not eligible for a Premium Tax Credit.

MHS

Patrick Rooney
CEO and Plan President

Ambetter ~~from MHS~~Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you", "your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits~~*loss* due to *illness* or bodily *injury*~~ as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

~~From time to time~~Annually, *we* ~~will~~ may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- how How to access medical care;
- Wwhat health services are covered by *us*, and
- Wwhat portion of the health care costs *you* will be required to pay.

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

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

How to Contact Us

Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST

Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency - Call **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services

Ambetter from MHS has a free service to help our *members* who speak languages other than English. Some *members* do not speak English. Others speak English, but it is not their preferred language. *We* have a free service to help *our members* who don't feel comfortable speaking English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand. *Our* interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. They can help with many different languages. This includes sign language and many others. *We* also have Spanish-speaking representatives. They can help our Spanish-speaking *members* when they call. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

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To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice complaints or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include ~~the following~~:

a. Any changes in clinical review criteria; or
b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*. ~~You can also get information on *your network providers'* education, training, and practice.~~
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.

5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member*. *We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
~~5.~~7. Notice of Privacy Practices.
~~6.~~8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items abut 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 physician* or service provided by *us*, please contact the Member Services Department.

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

DEFINITIONS

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

Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance ~~***payments of the***~~ ***premium tax credit*** means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return. ~~payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a *QHP* through an Health Insurance Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.~~

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; copayment amounts; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or an Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses. ~~. For family coverage, once a *covered person* has met the individual *deductible amount*, the remainder of the family *deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses.*~~

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

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* lawful *spouse* and/or an *eligible child*.

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,*~~ *covered services.*

Eligible child means the~~*your or your spouse's*~~ child of a *covered person*, if that child is less than 26 years of age. As used in this definition, "child" means:

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

~~4.~~ It is *your* responsibility to notify ~~*us*~~ the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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* or;
   b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts
   c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify *us* or verify that your Physician has notified *us* of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically

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Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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. ~~determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include the following general categories and the items and services covered within the 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.~~

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"~~US~~FDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *~~US~~FDA* approval, and:
    a. It does not have *~~US~~FDA* approval;
    b. It has *~~US~~FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *~~US~~FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *~~US~~FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *~~US~~FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *~~US~~FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

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

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

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 *generally accepted standards of medical practice* for that condition.

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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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care.*

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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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an

employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses. ~~For the family maximum out-of-pocket amount, once a *covered person* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more covered persons' eligible expenses.~~

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

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder. ~~*you, your* lawful *spouse* and each *eligible child*:~~
~~Named in the application; or~~
~~Whom *we* agree in writing to add as a *member*.~~

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

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

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

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

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

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:
1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

Qualified Individual means, with respect to an 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.

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

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

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
2. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child ~~The first day of the premium period/first full calendar month after the date of becoming *your dependent*.~~

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Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

~~Adding~~ Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, we will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for~~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 on the same basis as any other dependent. .

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

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

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

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*; or
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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 Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.

All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

We must receive notification within 120 days of the date a *dependent member* ceases to be an eligible *dependent member*. If notice is received by *us* more than 120 days from this date, any unearned premium will be credited only from the first day of the *policy*/calendar month in which *we* receive the notice.

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. Chiefly dependent on the primary *member*you for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins October 1, 2013November 15, 2014 and extends through March 31, 2014February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2013 will have an *effective date* of coverage on January 1, 2014 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2013 2014 and March 31, 2014January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. *Qualified individuals* who enroll prior to December 7, 2013 will have an *effective date* of coverage on January 1st of the following year.

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period ~~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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

~~With respect to individuals enrolled in non-calendar individual health insurance policies, there will be a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy ends in 2014.~~

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

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

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.* ~~A due date is the last day of the period for which the preceding premium was paid.~~

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement Of Residence
If *you* change *your residence*, *you* must notify the Exchange ~~*us*~~ of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information . ~~*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* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional covered service expenses will be 100%.

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*.~~; and~~
   ~~2.~~

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

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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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department. ~~calling the telephone number shown on the front page of this *contract*~~.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. ~~For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* in order to be eligible for maximum benefits under this *contract.*~~

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers. You* will be notified of any increase in premium.

Changing the Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits

Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*~~autism spectrum disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association~~. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. Inpatient ~~psychiatric~~ treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate

1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services; ~~and~~
3. Biofeedback; and
4. Psychological Testing.
5. ~~Biofeedback~~

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.

2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*

4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.
    b. Infusion pump or cassette.
    c. Portable commode.
    d. Patient lift.
    e. Bili-lights.
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:
1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.

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

~~1. Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*~~

Miscellaneous Major Medical Expense Benefits

Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy ~~for breast cancer~~. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.

17. For maternity care ~~of the *Member* or *Member's spouse*~~: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.
    ~~19.~~

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Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*
   ~~1.~~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 that 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.

~~2.~~

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

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

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off label use, except as otherwise prohibited by law or as approved by Us.

Pediatric Vision Expense Benefits

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy; or
2. Two pair of glasses as a substitute for bifocals.
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a covered service; or
5. Non-Network Providers

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage

Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care provider without prior authorization.

4.

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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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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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 health care 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.

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

- 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.

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

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

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

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*

b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services And Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("~~US~~*FDA*") regulation, regardless of whether the trial is subject to ~~US~~*FDA* oversight.

Limitations On Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

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

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

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

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

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

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract* , 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*, bariatric surgery and weight loss programs, except as specifically covered in the Preventive Services section of the *contract*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization~~serialization~~ and reversal vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities.
    ~~17. For diagnosis or treatment of nicotine addiction.~~
    ~~18.~~17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

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~~19.~~18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.

~~20.~~19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

~~21.~~20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract).*

~~22.~~21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy , except as expressly provided for in this *contract.*

~~23.~~22. 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.

23. 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*.

24. For hearing aids, except as expressly provided in this *contract.*

~~24.~~

25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm. ~~(whether the *member* is sane or insane).~~
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.

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35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol,

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners
Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination Of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

~~6.~~

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~~*We* will refund any~~Paid premiums ~~paid and~~that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

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

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

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage

If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as

this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

~~**Continuation of Coverage**~~
~~*We* will issue the continuation of coverage:~~
1. ~~No less than 30 days prior to a *member's* 26th birthday; or~~
2. ~~Within 30 days after the date *we* receive timely notice of *your* legal divorce or *dependent member's* marriage. *Your* former *dependent member* must pay the required premium within 31 days following notice from *us* or the new *contract* will be void from its beginning.~~

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:
1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:
1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

~~During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *contract,* including those stated in the Premiums section of this *contract,* will apply as though coverage had remained in force for that *illness* or *injury*.~~

REIMBURSEMENT

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

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
   ~~3. or any other~~
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include ~~Indivdiual~~Individual or Family:
   Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. ~~(1) t~~The plan has no order of benefits rules or its rules differ from those required by regulation; or

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

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

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

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

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

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

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

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

Time for Payment Of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

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*.

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

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

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

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

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

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant*;*
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within ~~5 (five)~~three (3) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
   (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
   (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
   (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
   a. That *we* have not resolved the *grievance*;
   b. When *our* resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.
   ~~1.~~

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Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.
The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:
A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within ~~5~~ three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within ~~5~~ three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are covered services, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals* procedures apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

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

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

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

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

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

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

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

Ambetter ~~from MHS~~Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you", "your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered ~~*loss* due to *illness* or bodily *injury*~~*benefits* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

~~From time to time~~Annually, *we* ~~will~~ may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- ~~h~~How to access medical care~~,~~.
- W~~w~~hat health services are covered by *us*.,
- ~~and~~ W~~w~~hat portion of the health care costs *you* will be required to pay.

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

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

How To Contact Us

Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST

Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**

Emergency - ~~Call~~ **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services

Ambetter from MHS has a free service to help our *members* who speak languages other than English.~~Some *members* do not speak English. Others speak English, but it is not their preferred language. *We* have a free service to help *our members* who don't feel comfortable speaking English.~~ This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand. *Our* interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. ~~They can help with many different languages. This includes sign language and many others. *We* also have Spanish-speaking representatives. They can help our Spanish-speaking *members* when they call.~~ *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

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

guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include the following:

a. Any changes in clinical review criteria; or
b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*. ~~*You* can also get information on *your network providers'* education, training, and practice.~~
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of

covered services.

5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member*. *We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*. The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website

Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/ . It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

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

DEFINITIONS

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

Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance ~~***payments of the***~~ ***premium tax credit*** means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return. ~~payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a *QHP* through an Health Insurance Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.~~

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses. ~~. For family coverage, once a *covered person* has met the individual *deductible amount*, the remainder of the family *deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses.*~~

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

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* lawful *spouse* and/or an *eligible child*.

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.*~~*covered services.*

Eligible child means ~~*your or your spouse's*~~the child of a *covered person*, if that child is less than 26 years of age. As used in this definition, "child" means:

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

~~4.~~ It is *your* responsibility to notify ~~*us*~~ the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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*~~-or~~;
   b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
   c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify *us* or verify that your Physician has notified *us* of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically

Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless *we* authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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. ~~are determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include the following general categories and the items and services covered within the 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.~~

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("~~US~~*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to ~~US~~*FDA* approval, and:
    a. It does not have ~~US~~*FDA* approval;
    b. It has ~~US~~*FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has ~~US~~*FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a ~~US~~*FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has ~~US~~*FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the ~~US~~*FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

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

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

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 *generally accepted 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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an

employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses. ~~For the family maximum out-of-pocket amount, once a *covered person* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more covered persons' eligible expenses.~~

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner ~~means a~~includes, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder[MB1]. ~~*you*, *your* lawful *spouse* and each *eligible child*:~~
~~Named in the application; or~~
~~Whom *we* agree in writing to add as a *member*.~~

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

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

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

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

Network eligible service expense means the *eligible 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 means a *medical practitioners* ~~*physician* or provider~~ who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:
1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

Qualified Individual means, with respect to an 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.

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac

rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child 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,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Adding Coverage for aA 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Adding AnCoverage for 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 on the same basis as any other dependent.

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

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

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

Adding Other Dependent Members

If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*; ~~or~~
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or~~.~~
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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 Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.

~~*We* must receive notification within 120 days of the date a *dependent member* ceases to be an eligible *dependent member*. If notice is received by *us* more than 120 days from this date, any unearned premium will be credited only from the first day of the *policy*/calendar month in which *we* receive the notice.~~

All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on the primary *member*~~*you*~~ for support.

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins ~~October 1, 2013~~November 15, 2014 and extends through ~~March 31, 2014~~February 51, 2015. *Qualified individuals* who enroll prior to December 15, ~~2013~~ 2014 will have an *effective date* of coverage on January 1, ~~2014~~2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December ~~2013~~ 2014 and ~~March 31, 2014~~January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

~~For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. *Qualified individuals* who enroll prior to December 7, 2013 will have an *effective date* of coverage on January 1st of the following year.~~

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period~~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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

~~With respect to individuals enrolled in non-calendar individual health insurance policies, there will be a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy ends in 2014.~~

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

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

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*.~~A due date is the last day of the period for which the preceding premium was paid.~~

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange~~*us*~~ of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information. ~~*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* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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*.~~; and~~
   ~~2.~~

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by ~~calling the telephone number shown on the front page of this *contract*~~contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. ~~For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* in order to be eligible for maximum benefits under this *contract.*~~

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy,* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing the Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including ~~*autism spectrum disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*~~*pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. Inpatient ~~psychiatric~~ treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate

1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services; ~~and~~
3. Biofeedback; and
4. Psychological Testing.
5. ~~Biofeedback~~

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.

2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*

4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.
    b. Infusion pump or cassette.
    c. Portable commode.
    d. Patient lift.
    e. Bili-lights.
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:
1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.

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

~~1. Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*~~

Miscellaneous Major Medical Expense Benefits

Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy ~~for breast cancer~~. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.

17. For maternity care ~~of the *Member* or *Member's spouse*~~: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

~~19.~~

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*

~~1.~~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 that 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.

~~2.~~

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

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

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care..
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy; or
2. Two pair of glasses as a substitute for bifocals.
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age or older

Routine eye exams, prescriptions eyeglasses, and standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.3451

Non-Routine Vision Adult 19 years of age and over and Pediatric
Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Other Dental Services
Anesthesia and Hospital charges for dental care, for a *member* less than 19 years of age or a *member* r who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage
Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care provider without prior authorization.

~~4.~~

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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage [MF2]
Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

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

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

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"~~US~~FDA"*) regulation, regardless of whether the trial is subject to *~~US~~FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

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

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

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

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

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

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract* , 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*, bariatric surgery and weight loss programs, except as specifically covered in the Preventive Services section of the *contract*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of ~~serialization~~ sterilization and reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities.

~~17. For diagnosis or treatment of nicotine addiction.~~

~~18.~~17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

~~19.~~18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.

~~20.~~19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

~~21.~~20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.

~~22.~~21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy , except as expressly provided for in this *contract*.

~~23.~~22. 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.

23. 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*.

24. For hearing aids, except as expressly provided in this *contract.*

~~24.~~

25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm ~~(whether the *member* is sane or insane)~~.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.

35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol,

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination Of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

~~6.~~

~~*We* will refund any~~Paid premiums ~~paid and~~that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

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

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

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage

If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as

this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

~~**Continuation of Coverage**~~
~~*We* will issue the continuation of coverage:~~

1. ~~No less than 30 days prior to a *member's* 26th birthday; or~~
2. ~~Within 30 days after the date *we* receive timely notice of *your* legal divorce or *dependent member's* marriage. *Your* former *dependent member* must pay the required premium within 31 days following notice from *us* or the new *contract* will be void from its beginning.~~

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

~~During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *contract,* including those stated in the Premiums section of this *contract,* will apply as though coverage had remained in force for that *illness* or *injury.*~~

REIMBURSEMENT

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

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid ~~or any other~~ .
   ~~3.~~
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. ~~(1) the~~ The plan has no order of benefits rules or its rules differ from those required by regulation; or

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

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;

    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-

parent's plan will pay second, and the plan of the parent without custody will pay third.

c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

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

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

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

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

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

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

Time For Payment Of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

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*.

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

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

~~Medcaid~~Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

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

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within ~~5 (five)~~3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
   (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
   (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
   (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
   a. That *we* have not resolved the *grievance*;
   b. When *our* resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within ~~5~~ three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) ~~5~~ business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE

If you are still receiving the services that are under appeal, and the services are covered services, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW

The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee

Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION

We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals* procedures apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

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

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

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

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

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

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

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

Ambetter ~~from MHS~~Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you", "your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered ~~*loss* due to *illness* or bodily *injury*~~benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

~~From time to time~~Annually, *we* ~~will~~ may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- ~~how~~ How to access medical care~~,~~.
- ~~what~~ What health services are covered by *us*~~,~~ .~~and~~
- W~~w~~hat portion of the health care costs *you* will be required to pay.

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

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

How To Contact Us

Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST

Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency - ~~Call~~ 911
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services

Ambetter from MHS has a free service to help our *members* who speak languages other than English. ~~Some *members* do not speak English. Others speak English, but it is not their preferred language. *We* have a free service to help *our members* who don't feel comfortable speaking English.~~ This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand. *Our* interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. ~~They can help with many different languages. This includes sign language and many others. *We* also have Spanish-speaking representatives. They can help our Spanish-speaking *members* when they call.~~ *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-

9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice complaints or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include the following:

a. Any changes in clinical review criteria; or
b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*. ~~*You* can also get information on *your network providers'* education, training, and practice.~~
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.

5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member*. *We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*. The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website

Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practice.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

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

services *you* are receiving.

DEFINITIONS

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

Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance ~~***payments of the***~~ ***premium tax credit*** means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return. ~~payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a *QHP* through an Health Insurance Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.~~

Adverse benefit determination means:

Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.~~For family coverage, once a *covered person* has met the individual *deductible amount*, the remainder of the family *deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses.*~~

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

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* lawful *spouse* and/or an *eligible child*.

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.*~~*covered services.*

Eligible child means -the child of a covered person~~*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 child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

~~4.~~ It is *your* responsibility to notify *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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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*~~-or~~;
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify *us* or verify that your Physician has notified *us* of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically

Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless *we* authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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. ~~determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include the following general categories and the items and services covered within the 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.~~

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("~~US~~*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to ~~US~~*FDA* approval, and:
    a. It does not have ~~US~~*FDA* approval;
    b. It has ~~US~~*FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has ~~US~~*FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a ~~US~~*FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has ~~US~~*FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the ~~US~~*FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

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

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 *generally accepted 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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an

employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses. ~~For the family maximum out-of-pocket amount, once a *covered person* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more covered persons' eligible expenses.~~

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner ~~means~~ includes, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including any enrollee, subscriber or policy holder. ~~*you, your* lawful *spouse* and each *eligible child*:~~

~~1. Named in the application; or~~

~~2. Whom *we* agree in writing to add as a *member*.~~

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

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

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

Network means a group of *Medical Practitioners* ~~*physicians*~~ and providers who have contracts that include an agreed upon price for health care 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 means a *Medical* ~~*physician* or provider who~~*Practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:
1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

Qualified Individual means, with respect to an 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.

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac

rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

~~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,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

~~Adding~~ Coverage For 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

~~Adding~~ Coverage For 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 on the same basis as any other dependent.

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

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

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

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*; or
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes;. or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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 Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month. .

We must receive notification within 120 days of the date a *dependent member* ceases to be an eligible *dependent member*. If notice is received by *us* more than 120 days from this date, any unearned premium will be credited only from the first day of the *policy*/calendar month in which *we* receive the notice.

All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *you* the primary *member* for support.

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins October 1, 2013November 15, 2014 and extends through March 31, 2014February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2013 will have an *effective date* of coverage on January 1, 2014 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2013 2014 and March January 31, 2014 2015, will have a coverage *effective date* of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. *Qualified individuals* who enroll prior to December 7, 2013 will have an *effective date* of coverage on January 1st of the following year.

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special And Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Perio~~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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

~~With respect to individuals enrolled in non-calendar individual health insurance policies, there will be a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy ends in 2014.~~

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

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

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.* ~~A due date is the last day of the period for which the preceding premium was paid.~~

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement Of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Or Misstatement Of Residence
If *you* change *your residence*, *you* must notify the Exchange~~*us*~~ of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information. ~~*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* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional covered service expenses will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department. ~~calling the telephone number shown on the front page of this *contract.*~~

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. ~~For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* in order to be eligible for maximum benefits under this *contract.*~~

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders.* ~~autism spectrum disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.~~ Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. Inpatient ~~psychiatric~~ treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate

1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services; ~~and~~
3. Biofeedback; and
4. Psychological Testing.
5. ~~Biofeedback~~

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.

Habilitation, Rehabilitation And Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.

3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.

7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.
    b. Infusion pump or cassette.
    c. Portable commode.
    d. Patient lift.
    e. Bili-lights.
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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

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

~~a.~~

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

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

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

~~Exclusions And Limitations:~~
~~Any exclusion or limitation contained in the *contract* regarding:~~

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

~~1. Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*~~

Miscellaneous Major Medical Expense Benefits

Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy ~~for breast cancer~~. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care ~~of the *Member* or *Member's spouse*~~: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and

hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
~~19.~~22. Allergy Testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*
~~1.~~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 that 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.

~~2.~~5.

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

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

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off label use, except as otherwise prohibited by law or as approved by *us*.

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a covered service; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by

an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, Basic (Class 1) and Comprehensive (Class 2) dental services from an *In-Network provider*. *Covered services* for restorative care are subject to a 6 month waiting period. Please refer to your Schedule of Benefits for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which dental providers are part of the network, please call Member Services or visit http://ambetter.mhsindiana.com/ .

1. Basic (Class 1) benefits include:
   a. Routine Oral Exams;
   b. Routine Cleanings;
   c. Bite-wing X-rays;
   d. Full-Mouth X-Rays;
   e. Panoramic Film;
   f. Topical fluoride application; and
   g. Palliative Treatment for Relief of Pain (minor procedures).
2. Comprehensive (Class 2) benefits include:
   a. Basic Services – including silver filings and tooth colored filings;
   b. Endodontics – including therapeutic pulpotomy;
   c. Periodontics – including scaling, root planning and periodontal maintenance;
   d. Oral Surgery – including simple extractions, surgical extractions, removal of impacted tooth and alveoloplasty; and
   e. Prosthodontics – including relines, rebase, adjustment and repairs.

Services not covered for adult Basic (Class 1) and Comprehensive (Class 2) benefits include:

1. Out of network services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. Prescription drugs;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the member's *effective date* of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;

9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant procedures;
11. Surgical replacements;
12. Sinus augmentation;
13. Surgical appliance removal;
14. Intraoral placement of a fixation device;
15. Oral hygiene instruction, tobacco counseling, nutritional counseling;
16. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
17. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
18. Root canal therapy;
19. Analgesia (nitrous oxide);
20. Removable unilateral dentures;
21. Temporary procedures;
22. Splinting;
23. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
24. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
25. Consultations by the treating provider and office visits;
26. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's *effective date*;
27. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
28. Veneers (bonding of coverings to the teeth);
29. Orthodontic treatment procedures;
30. Corrections to congenital conditions, other than for congenital missing teeth;
31. Athletic mouth guards;
32. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment; and
33. Space maintainers for anyone 19 years of age or older.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage

Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests

Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the

patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

If *we* determine that a *member* is an appropriate candidate for a *listed 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.

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

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

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services ~~And~~ and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"~~US~~FDA"*) regulation, regardless of whether the trial is subject to ~~US~~*FDA* oversight.

Limitations ~~On~~ on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits

Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

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

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

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

Failure To Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

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

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

Requests For Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric surgery and weight loss programs, except as specifically covered in the Preventive Services section of the *contract*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization~~serialization~~ and reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities

~~17. For diagnosis or treatment of nicotine addiction.~~

~~18.~~17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

~~19.~~18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.

~~20.~~19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

~~21.~~20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.

~~22.~~21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy , except as expressly provided for in this *contract*.

~~23.~~22. 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.

23. 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*.

24. For hearing aids, except as expressly provided in this *contract.*

~~24.~~

25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm. ~~(whether the *member* is sane or insane).~~
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.

35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol,

Limitations On Benefits For Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination Of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

We will refund anyPaid premium paid andthat are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

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

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

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability Of Coverage

If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent

satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

~~**Continuation of Coverage**~~
~~*We* will issue the continuation of coverage:~~

1. ~~No less than 30 days prior to a *member's* 26th birthday; or~~
2. ~~Within 30 days after the date *we* receive timely notice of *your* legal divorce or *dependent member's* marriage. *Your* former *dependent member* must pay the required premium within 31 days following notice from *us* or the new *contract* will be void from its beginning.~~

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

~~During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *contract,* including those stated in the Premiums section of this *contract,* will apply as though coverage had remained in force for that *illness* or *injury*.~~

REIMBURSEMENT

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

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
   ~~3. or any other~~
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. ~~(1) the~~ The plan has no order of benefits rules or its rules differ from those required by regulation; or

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

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;

    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

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

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

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

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

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

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

Time For Payment Of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:

1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

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

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

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

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

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

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within ~~5 (five)~~3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
   (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
   (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
   (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
   a. That *we* have not resolved the *grievance*;
   b. When *our* resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an ~~internal~~ Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within ~~5~~ three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) ~~5~~ business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE

If you are still receiving the services that are under appeal, and the services are covered services, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW

The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee

Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION

We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.

- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.
- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals* procedures apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

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

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

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

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

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

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

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

[Plan Information]

[Health Plan:]	[Plan Name~~Ambetter Gold 2~~[MF1]]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15][MB2]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care ~~(including well baby visits)~~	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Wellness Program	$25 to $250	

The benefit available for participation in a wellness program will usually be in the form of a credit added to a debit card *we* issue to the *member* and, depending on the particular wellness program, is usually between $25 and $250. Discounts also may be available for participating in a wellness program. You may obtain information regarding the available wellness programs, the requirements for participation in each wellness program and the benefits available for participating in a particular wellness program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

*Requires prior authorization – please contact the number listed on your ID card

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

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

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

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

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

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

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

DEFINITIONS

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

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

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

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

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

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

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

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

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

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* lawful *spouse* and/or an *eligible child*.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

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

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 *generally accepted 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.

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

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

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

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

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

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

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

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

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

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

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

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

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

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

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

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

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

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

Period of extended loss means a period of consecutive days:

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

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Post-service claim means any claim for 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.

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

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

Prescription drug deductible amount means the amount of *covered 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 expenses*.

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

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

Prosthetic device means an artificial leg or arm.

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

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

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

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

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

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

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

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

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

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

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

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

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

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

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

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

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

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

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

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

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

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

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

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

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

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

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

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

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

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

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

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

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

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

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

Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

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

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for

at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

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

1. A *prescription drug.*
2. 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 that 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.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her Medical Practitioner.

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits
Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:
1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Other Dental Services
Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage
Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.

2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death.

Reinstatement
We will reinstate a policy when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant*;*
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your"*, *"yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and refuse to renew all polices 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.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

a. Any changes in clinical review criteria; or
b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at http://ambetter.mhsindiana.com/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter from MHS Network. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member*. *We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed 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.*

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Contract when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

The *deductible amount* does not include any copayment amounts.

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* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

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 *generally accepted 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.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services.
2. Determination to reform or rescind a policy.
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:
1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-Network Provider means a *medical practitioner* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Post-service claim means any claim for 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.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered 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 expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Prosthetic device means an artificial leg or arm.

Provider facility means a *hospital, rehabilitation facility*, or *extended care facility*.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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 Indiana to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members
A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract, we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers. You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

a. Daily room and board and nursing services.
b. Diagnostic testing.
c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
   a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.
   ~~8.~~

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Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room.
d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of*

pregnancy, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. 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 that 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.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her Medical Practitioner.

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits
Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Other Dental Services
Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage
Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.

5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract. You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death.

Reinstatement
We will reinstate a policy when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant*;*
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
   (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
   (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
   (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
   a. That *we* have not resolved the *grievance*;
   b. When *our* resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.
The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:
A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and refuse to renew all polices 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.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at http://ambetter.mhsindiana.com/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter from MHS Network. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed 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.*

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Contract when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

The *deductible amount* does not include any copayment amounts.

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* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

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 *generally accepted 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.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services.
2. Determination to reform or rescind a policy.
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-Network Provider means a *medical practitioner* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Post-service claim means any claim for 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.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered 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 expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Prosthetic device means an artificial leg or arm.

Provider facility means a *hospital, rehabilitation facility*, or *extended care facility*.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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 Indiana to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members
A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract, we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.

Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person.*

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room.
d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of*

pregnancy, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

18. 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.
19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. 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 that 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.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her Medical Practitioner.

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits
Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:
1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, Basic (Class 1) and Comprehensive (Class 2) dental services from an *In-Network provider*. *Covered services* for restorative care are subject to a 6 month waiting period. Please refer to your Schedule of Benefits for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which dental providers are part of the network, please call Member Services or visit http://ambetter.mhsindiana.com/.

1. Basic (Class 1) benefits include:
   a. Routine Oral Exams;
   b. Routine Cleanings;
   c. Bite-wing X-rays;
   d. Full-Mouth X-Rays;
   e. Panoramic Film;
   f. Topical fluoride application; and
   g. Palliative Treatment for Relief of Pain (minor procedures).
2. Comprehensive (Class 2) benefits include:
   a. Basic Services – including silver filings and tooth colored filings;
   b. Endodontics – including therapeutic pulpotomy;
   c. Periodontics – including scaling, root planning and periodontal maintenance;
   d. Oral Surgery – including simple extractions, surgical extractions, removal of impacted tooth and alveoloplasty; and
   e. Prosthodontics – including relines, rebase, adjustment and repairs.

Services not covered for adult Basic (Class 1) and Comprehensive (Class 2) benefits include:

1. Out of network services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. Prescription drugs;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the member's *effective date* of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant procedures;
11. Surgical replacements;
12. Sinus augmentation;
13. Surgical appliance removal;

14. Intraoral placement of a fixation device;
15. Oral hygiene instruction, tobacco counseling, nutritional counseling;
16. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
17. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
18. Root canal therapy;
19. Analgesia (nitrous oxide);
20. Removable unilateral dentures;
21. Temporary procedures;
22. Splinting;
23. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
24. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
25. Consultations by the treating provider and office visits;
26. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's *effective date*;
27. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
28. Veneers (bonding of coverings to the teeth);
29. Orthodontic treatment procedures;
30. Corrections to congenital conditions, other than for congenital missing teeth;
31. Athletic mouth guards;
32. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment; and
33. Space maintainers for anyone 19 years of age or older.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage

Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.

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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage
Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and

3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this

reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death.

Reinstatement
We will reinstate a policy when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Dear Karl Knable,

Below are the responses to your objections dates May 19, 2014. Please let us know if you would like to discuss these further.

1. **We need you to acknowledge that all filings are public information on submission.**

We acknowledge that all filings are public upon submission.

2. **Please provide the distribution by age and geographic region for what is inforce for 2014.**

Below is our current distribution by Age and Rating Areas:

Age Distribution – Active Enrollees as of 4/14/2014

Age Bracket	# of Members
0-20	23
21-25	37
26-30	71
31-35	69
36-40	52
41-45	41
46-50	38
51-55	39
56-60	65
61-64	76
Total	**511**

Area Distribution - Active Enrollees as of 4/14/2014

Rating Area	# of Members
Rating Area 2	117
Rating Area 3	182
Rating Area 4	212
Grand Total	**511**

3. **Please provide additional documentation on the development of the geographic factors. Specifically explain how region 13 is 188% higher than region 16.**

The difference in the area factors for Region 13 and 16 is primarily driven by unit cost differences.

4. **How were the tobacco factors developed? You cannot use tobacco factors below age 21. Also explain age 45-46 factors.**

The tobacco factors relied upon Milliman research performed for the Nevada Silver State Exchange. The study is available upon public records request. It is based upon an analysis of publicly available cost experience by wider age brackets than the standard age curve. The rating for ages under 21 is consistent with our approach last year. It is our understanding that individuals who are legally of age to consume tobacco can be rated up for tobacco use, in compliance with 45 CFR 147.102(a)(1)(iv). This includes people between 18 and 21. Since HHS has not included age tiers separate age tiers for those under 18 and those between 18 and 21, we have reflected the tobacco load for the entire tier. From an operations standpoint there are efforts in place to disallow prospects under 18 from claiming they are tobacco users.

Some of the tobacco loads may look odd as you have pointed out for ages 45-46. This was a result of some of the glitches in the rate table template validation last year and required some manual tweaks in order for the table to validate.

Note: these factors have been modified since last year's filing to align all of our tobacco loads across all of the states we support.

5. **Under Section 6, please provide some additional information on the transitions mentioned. Where does this come into play in the index rate development?**

Employer Plan Termination, Voluntary Employee Termination, and Early Retirement

The State Impact Model (SIM) models net transitions from pre-ACA Large Group/Small Group, Fully Insured/Self-Funded, Full-Time/Part-Time, and Active/Retiree employer sponsored insurance to the Indiana Individual Exchange market.

The SIM assumes that termination of employer coverage will primarily affect lower income (< 200% FPL) and part-time enrollees (although some discontinuation of coverage for full time employees above 200% FPL is assumed), and small group employer terminations are assumed to be more frequent than large group terminations. Average termination rates (voluntary and involuntary) are expected to rise as employee health status worsens.

Employees with incomes above 138% FPL are assumed to primarily transition to individual exchange coverage, with a rising percentage choosing instead to remain uninsured as income increases and subsidies decline.

The SIM also assumes that some persons aged 50-64 with employer coverage will be motivated to retire early and transition to individual coverage.

We calibrated aggregate 2014 SIM transition rates from employer group coverage to the Indiana Individual Exchange using state-specific transition rates from the March 2013 SOA/Optum study "Cost of the Future Newly Insured under the Affordable Care Act (ACA),"[1] dampened to approximate emerging 2014 enrollment rates implied by the February 11, 2014 HHS ASPE Issue Brief "Health Insurance Marketplace: February 2014 Enrollment Report"[2].

[1] http://www.soa.org/newlyinsured/
[2] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

Uninsured Insurance Participation

The SIM models variation in uninsured participation rates by age, with the lowest participation rates for children and the highest for adults aged 50-64. The SIM assumes that uninsured participation rates are highest at lower incomes, due to the availability of cost sharing subsidies and premium assistance.

We calibrated uninsured participation rates in the SIM based on emerging 2014 enrollment rates implied by the February 11, 2014 HHS ASPE Issue Brief "Health Insurance Marketplace: February 2014 Enrollment Report". The SIM assumes that uninsured participation will continue through 2015 at the same rates projected for 2014 (but from a smaller, healthier pool of uninsured).

Disenrollment from the Individual Market as a Reaction to Post-ACA Community Rating

We expect that ACA adjusted community rating restrictions will result in older and less healthy enrollees in the individual insurance exchanges being subsidized by the younger and healthier insured population.

Furthermore, we believe that despite penalties and premium subsidies, the switch to community rating will have caused the individual market to become financially unattractive to some young, healthy members of the pre-2014 individual insurance population.

The SIM varies individual market disenrollment rates by age, gender, FPL, and health status. Males, young enrollees, and those in excellent health have the highest assumed disenrollment rates. Females, aged enrollees, and those in fair/poor health have the lowest assumed disenrollment rates.

We calibrated the disenrollment rate in Indiana to the state-specific rate in the March 2013 SOA/Optum study "Cost of the Future Newly Insured under the Affordable Care Act (ACA)." We modeled this impact as a one-time event, such that no additional net disenrollment was projected after 2014.

Exchange Participation by Existing Off-Exchange Individual Insurance Enrollees

The SIM assumes that a substantial portion of the pre-2014 individual insurance market transitions to QHPs on the Indiana Exchange beginning in 2014. This transition is assumed highest at lower incomes, due to the availability of cost sharing subsidies and premium assistance for plans on the Exchange. Most of the rest of the market is projected to transition to Off-Exchange QHPs.

We calibrated aggregate 2014 migration from pre-2014 individual insurance coverage to the Indiana Individual Exchange using state-specific transition rates from the March 2013 SOA/Optum study "Cost of the Future Newly Insured under the Affordable Care Act (ACA)," dampened to approximate emerging 2014 enrollment rates implied by the February 11, 2014 HHS ASPE Issue Brief "Health Insurance Marketplace: February 2014 Enrollment Report".

For our 2015 projections, we projected a continued migration from Off-Exchange plans to Individual Exchange plans, but at a reduced rate relative to the transitions in 2014.

State and Federal High Risk Pool Termination

The SIM projects that State and Federal High Risk Pool enrollees in Indiana will transition to Individual Exchange plans.

Description of how the above transitions come into play in the index rate development:

The State Impact Model (SIM) enrollment projections for 2015 reflect the transitions above. Likewise, projected morbidity for the Indiana statewide risk pool and Individual Exchange market reflects the mix of age, gender, and health status of those projected to transition into the risk pool and Exchange market.

Coordinated Care Corporation's projected membership is based on the SIM projected statewide Exchange demographics. Morbidity for these members is based on the SIM projected statewide Exchange morbidity. As described in the answer to Objection #7, claim costs underlying the index rate reflect the projected demographic mix and morbidity of the expected Coordinated Care Corporation membership.

The index rate also reflects projected risk adjustment transfer receivables. As demonstrated in the answer to Objection #11, the projected risk adjustment transfer receivable reflects the projected demographics and morbidity of the Coordinated Care Corporation enrollees and Indiana's statewide individual risk pool.

6. You use a pent-up demand factor of 2.5% for members reporting excellent or good health. Please elaborate on this.

Pent-up demand is intended to account for the increase in utilization that we expect to see with those who become newly insured. We would expect to see some pent-up demand regardless of health status. This is due to the assumption that there is an increased likelihood of utilizing discretionary services after becoming newly insured for all individuals.

We would expect to see pent-up demand in individuals reporting excellent or good health but to a lesser degree. Therefore, we are applying a load of 2.5% for those reporting excellent or very good health and 5.0% for those reporting good or fair/poor health.

7. In Section 6, you indicate adjustments were made to calibrate the model according to expected population. Please provide specific information about the adjustments due to the 6 items shown.

The State Pricing Model manual rates begin with the Basic Tables from the Milliman Health Cost Guidelines™ (HCGs). The Basic Tables are nationwide utilization and billed charge assumptions for

over 50 categories of service. These nationwide utilization and billed charge values are then adjusted for several characteristics of the expected Coordinated Care Corporation population.

Here is specific information about each of the 6 adjustments:

Rating region

Area factors from the HCGs are used to adjust the Basic Tables for regional healthcare cost differentials and provider practice patterns for each rating region.

Expected demographics

Age/Gender factors from the HCGs are used to adjust the Basic Tables for the expected demographic make-up of the Coordinated Care Corporation population.

Expected morbidity

The HCG Basic Tables were developed based on experience for pre-2014 commercial group populations. In order to appropriately reflect Indiana's Individual Exchange population, an adjustment was made to utilization rates. This adjustment was calculated by the State Impact Model (SIM), based on the projected mix of health statuses of the 2015 Individual Exchange population relative to the pre-2014 employer group market, and the expected pent-up demand of the newly insured in the 2015 Individual Exchange market.

Provider Reimbursement

Allowed charge levels were calculated by adjusting the baseline pricing model unit cost based on Coordinated Care Corporation's contractual reimbursement rates.

Expected utilization management savings

DoHM (Degree of Healthcare Management) indicates the level of utilization management reflected within a plan's experience relative to the Milliman HCGs.

Little to no management is considered loosely managed, while the best practice management is considered well managed. The HCG Basic Tables includes separate loosely managed and well managed utilization and intensity values, which are blended based on a plan's anticipated DoHM.

Benefit plan designs

Modeled claims cost projections reflect Coordinated Care Corporation's specific benefit designs, including copays and coinsurance, deductibles, out-of-pocket maximums, the cost of capitated and non-EHB benefits, and induced utilization.

8. Please compare the capitated payments for services from this year to those from last year.

The following providers were utilized as capitated services in one or both of the 2014-2015 plan years.

- DentaQuest – Dental Services
- OptiCare – Vision Services
- Cenpatico – Behavioral Health & Specialty Rehabilitation Therapies
- Nurtur - Life & Health Management
- Nursewise - Telehealth Services (Medical Triage & Health Education)
- Teladoc – Telephone or Internet based consultation with a doctor
- Start Smart – Pregnancy and New Parent Education

The following table below shows the capitated rate on a *per member per month* basis:

Capitated Agreement	2014	2015	Difference
Denta Quest – Child	$0.00	$0.00	$0.00
Denta Quest – Adult	$18.79	$16.05	($2.74)
OptiCare – Child	$5.79	$5.04	($0.75)
OptiCare – Adult	$8.51	$6.38	($2.13)
Cenpatico	N/A*	$8.17	$8.17
Nurtur	$2.40	$2.40	$0.00
Nursewise	$0.75	$0.50	($0.25)
Teladoc	$0.09	$0.00	($0.09)
Startsmart	$0.06	$0.06	$0.00

*In 2014 Coordinated Care priced behavioral health (Cenpatico) as a non-capitated medical expense, but in 2015 it is priced under a capitated arrangement.

We would like to note that the capitated amounts in the URRT are weighted by our assumed membership mix and in 2014 we assumed no membership in the vision or vision + dental buy-up plans. This gave no weight to the Denta Quest – Adult or OptiCare Adult capitation rates. In 2015, however, we are estimating membership in these plans. The assumption change was driven by two factors: (1) CMS issued guidance around how carriers estimated membership in their plans and (2) we had membership from the first few months of 2014 on which to base these assumptions.

9. In Section 8, you discuss the Pd to Allowed ratio. Please explain some of the P to A assumptions that fall outside of the 2% +/- range for metal levels.

The paid to allowed factors in Appendix D are based upon our modeled ratios and not those of the Actuarial Value Calculator. Our model incorporates our specific unit cost and utilization assumptions, while the AV Calculator is a nationwide dataset. The 2% de minimis requirement is based off of the AV Calculator only.

10. In Section 9, did you consider the Medicaid Spend down assumptions in determining the State Average Premium?

We have incorporated an adjustment to our base rate to account for the Medicaid Spend Down population transition. However, our statewide average premium shown did not include this same load, which would have result in a leveraging of our assumed risk adjustment payment.

11. Please provide the calculations used in determining the ($25.52) risk adjustment value.

Please refer to Section 9 in the Coordinate Care Corporation Actuarial Memorandum for a description of the Risk Adjustment calculation steps.

Attachment A, included with this objection response, provides numeric support for how these calculations steps were followed to project a $25.52 risk adjustment receivable for Coordinated Care Corporation.

12. In Section 10, you indicate a $1.88 PMPM for quality improvement and $2.00 PMPM for provider incentives. Can you tie these back to your SHCE as to how this was determined.

No, these are estimates only and we don't have experience at this point to tie these to.

13. Provide a demonstration of how the 3% for the Health Insurance Provider fee was determined. Please do the same for the high risk pool.

The following is a demonstration of how we developed the ACA fee we are assuming in 2015.

2015 ACA Fee - Pricing Projection

Calendar Year	Carrier Health Insurer Fee	YOY % Increase for HIF Fee	Assumed Premium %	Non-Deductibility of Addt'l Premium Impact	Total ACA Fee % included in Premium
2014	$ 8,000,000,000		1.4%	0.7%	2.1%
2015	$ 11,300,000,000	41.3%			

	A 2014 ACA Fee % Estimate	B YOY % Increase HIF Fee (2014 to 2015)	(A*B)+A 2015 ACA Fee % Estimate	C multiplied by 41% 2015 Non-Deductibility of addt'l premium impact	C Total 2015 ACA Fee % included in Premium
2015 ACA Fee Rev %	1.4%	41.3%	1.9%	1.3%	3.2%

Notes

- Fee is not deductible from federal and state taxes. Assumed federal rate = 35%; state = 6%
- Estimate per Oliver Wyman (October, 2013) = 1.77% - 1.82% (net) and 2.8% (gross)
- Range of Estimates

2.80% per Oliver Wyman
3.20% as per calculation above
3.00% mid-point of the above-mentioned estimates

Conclusion:

Marketplace pricing for 2015 included an estimate of 3% in premium pricing for the Health Insurer Fee.

The estimate is for the Indiana interim assessments and annual fees. We anticipate that we will be assessed 0.4% to cover these expenses. This is the assessment as a percent of premium that our sister company, Celtic Insurance, was charged in recent years.

14. I will need last years index rate to be shown in the URRT, Section 1. Also, please include premiums and member months for the first 3 months of 2014. Claims are not needed at this time.

Section 1 on Worksheet 1 of the URRT includes Experience Period Data for CY 2013 only. We would therefore like to include the requested information for the first three months of CY 2014 separately from the URRT.

2014 Index Rate: $566.99
Premiums (Jan-Apr Only): $373,756
Member Months (Jan-Apr Only): 756

15. **In Appendix E, please explain what is SG&A?**

SG&A is our Selling, General and Administrative expenses. It includes both Health Plan as well as corporate expenses, but does not include profit.

16. **Also in Appendix E, please explain why the Exchange User Fee is applied to the index rate and not the expected average premium?**

Appendix E was developed to support the index rate calculation, which excludes non-EHBs. As such, the Exchange User Fee in row (d) of Appendix E is only applied to the EHB portion of benefits. The full Exchange User Fee we have built into our rates ($15.08 = 3.5% * $430.88) is based off of the expected average premium (inclusive of both EHBs and non-EHBs).

Attachment A
Coordinated Care Corporation
2015 Exchange Pricing
Development of Indiana Risk Adjustment Value

Indiana Statewide Individual Risk Pool			
	HHS Age/Gender Risk Score		1.338
	Health Status Risk Score (Statewide = 1.0)	x	1.000
	PLRS: Plan Liability Risk Score	=	1.338
	IDF: HHS Induced Demand Factor	x	1.072
	GCF: Geographic Cost Factor	x	1.000
(a)	**Plan Liability Component (PLRS x IDF x GCF)**	=	**1.435**
	AV: Metal Level AV		0.678
	ARF: Allowable Age Rating Factor	x	1.566
	IDF: HHS Induced Demand Factor	x	1.074
	GCF: Geographic Cost Factor	x	1.000
(b)	**Allowable Rating Component (AV*ARF*IDF*GCF)**	=	**1.141**

Coordinated Care Corporation			
	HHS Age/Gender Risk Score		1.360
	Health Status Risk Score (Statewide = 1.0)	x	1.065
	PLRS: Plan Liability Risk Score	=	1.449
	IDF: HHS Induced Demand Factor	x	1.099
	GCF: Geographic Cost Factor	x	1.000
(c)	**Plan Liability Component (PLRS x IDF x GCF)**	=	**1.592**
	AV: Metal Level AV		0.681
	ARF: Allowable Age Rating Factor	x	1.598
	IDF: HHS Induced Demand Factor	x	1.100
	GCF: Geographic Cost Factor	x	1.000
(d)	**Allowable Rating Component (AV*ARF*IDF*GCF)**	=	**1.197**

Risk Transfer Payment/(Receivable)		
Statewide Average Premium		$425.84
% of Statewide Average Premium = -(c/a - d/b)	x	-5.99%
Risk Transfer Payment/(Receivable)	=	**($25.52)**

1. Please provide detail for the expense PMPM of 49.11. I would like to see a more detailed split here.

Response:

Description	PMPM	% of Premium
Licensing and Taxes		
Premium Tax	$5.60	1.30%
Assessments	1.72	0.40%
FFE User Fee	15.08	3.50%
ACA Annual Fee (2015)	12.93	3.00%
CER (PCORI) Fee	0.17	0.04%
Risk Adjustment Admin Fee	0.08	0.02%
Licensing and Taxes - Total	$35.58	8.26%
Quality Improvement		
General Quality Improvement	$1.88	0.44%
Provider Incentives		
Pay for Performance	$2.00	0.46%
SG&A		
Core CNC Admin	$33.52	7.78%
Sales/Marketing	9.00	2.09%
Net Cost of Commercial Stop Loss	2.08	0.48%
Non-Medical Capitation Arrangements	4.51	1.05%
SG&A - Total	$49.11	11.40%

2. With the quality improvement and provider incentive PMPM estimate, please provide some description of what you will be doing in 2015 that may generate these expenses.

Response:

The budget for provider incentives was based on our 2015 contracting strategy in IN; specifically, innovative approaches related to provider reimbursement that are designed to achieve better health outcomes at lower costs. Specifically, the rate was determined based on the IN provider market and the level of cost savings desired. We anticipate savings to result from these partnerships through decreased utilization and improved care for the membership outside of the physicians' offices.

The quality improvement budget of $1.88 PMPM is designed to cover the costs that will be incurred that meet the NAIC definition of medical expense, as follows:

1) improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
2) prevent hospital readmissions;
3) improve patient safety and reduce medical errors, lower infection and mortality rates
4) increase wellness and promote health activities

5) enhance the use of health care data to improve quality, transparency, and outcomes. Specifically, the medical management staff employed by Coordinated Care Corporation in Indiana that employs strategies to improve health outcomes, including health management and complex case management, concurrent review and discharge planning is captured in this cost estimate.

3. It appears that you have three different products. Can you provide some additional discussion around the benefit differences between each?

Response:

Product 35065IN001 is the baseline standard plan which consists of all Essential health benefits, as well as state mandated benefits.

Product 35065IN002 is the baseline standard plan and includes adult vision as a buy up option.

Product 35065IN003 is the baseline standard plan and includes adult vision and adult dental as buy up options.

4. What is driving the unit cost differences between geographic regions?

Response:

Unit costs variances by geographic region are determined based on the Medicare base rate for a region and our contracted provider reimbursement rates.

5. With the tobacco rates, I still have concerns in instances where plan …N0020007 for rating area 10 has premiums of $524.62, $520.08 and $558.60 for ages 44, 45, and 46. I think this needs to be addressed.

Response:

As mentioned in an earlier response, the tobacco factors relied upon Milliman research performed for the Nevada Silver State Exchange. This study provided tobacco cost relativities summarized by several age brackets (e.g. 18-24, 25-34, etc…).

These factors were taken and broken out to each specific age using linear interpolation, where the composite of the age-specific factors for each bracket was set equal to those values from the study. The factors were then compressed in order to ensure tobacco rates fit within the required 3:1 band in the rate table template.

This methodology was used to smooth the increases that renewing members would have otherwise seen if we had used the age bracket adjustments as they were in the study. However, this approach also resulted in some of the nuances observed, such as the relationship between the 44 and 45 year olds' tobacco rates.

Note these factors have been modified since last year's filing to align all of our tobacco loads across all of the states we support.

6. I am a little confused. You state now that the premium rate increase is -3.2% rather than -8.8%, however, the URRT still shows a gross premium average of $430.88. Please explain and provide a demonstration of how you get to -3.3%.

Response:

The 3.2% decrease, previously an 8.8% decrease, represents the rate change for projected 2014 membership only. While the revised rates submitted on 6/13/2014 did not change our gross premium average or the composite 2015 area factor, different rating areas saw varying changes. Specifically, our 2014 rating areas (2, 3, and 4) saw an average increase in their area rating factors of 5.9% compared to the factors submitted as part of the original 2015 filing.

Compared to the 2014 area factors, there was an average increase of 5.0% in areas 2, 3, and 4. Other changes incorporated into the 3.2% total decrease are a 4.6% decrease in the base rate and a 3.3% decrease in the average plan factor, both of which are unchanged from the prior version.

7 "Pursuant 45 CFR §155.1020 and 45 CFR §156.210(c), QHP Issuers are required to prominently post the rate increase justification on your website prior to the implementation of the increase, see:

http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

§ 156.210 QHP rate and benefit information.

(a) General rate requirement. A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.

(b) Rate and benefit submission. A QHP issuer must submit rate and benefit information to the Exchange.

(c) Rate justification. A QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.

Please describe the method by which you meet the federal requirement

Response:

We are not requesting to increase rates, but instead are decreasing rates. Therefore, it is our understanding that no rate increase justification is necessary. However, should we request a rate increase in the future we are complying with the requirements of 45 CFR §155.1020 and 45 CFR §156.210(c) by posting to the website the information set out in 45 CFR §154.215(e).

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

	Sharing	
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2) - 6 month waiting period		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☑
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,400.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$250.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.08%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☑
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,400.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$250.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.08%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☑
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,400.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$250.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.08%
Metal Tier:	Silver

To: Karl Knable

From: Jonathan Szerszen; Steele Stewart

Date: 8/19/2014

Re: Coordinated Care Rate Change

Karl -

Consistent with prior conversations, we are proposing a 5% rate decrease due to a revised Degree of HealthCare Management (DoHM) assumption. DoHM indicates the level of utilization management reflected within the plan's experience relative to the Milliman HCG's. Utilization management may include reducing the intensity of services within a service category, or the frequency of services provided for a costly service. The DoHM assumption used in our previous filing was based on Coordinated Care's medical management of members reflecting current programs, practices and resources. Since our original filing, additional information regarding features of our medical management has become available.

The 2015 improvements are in comparison to the current 2014 Health Risk Assessment (HRA) we have in place. The 2014 HRA is currently incentivized with a $50 reward upon completion; however, it is only available through a member secure portal and included a large number of questions, both considered to be deterrents to members completing the survey.

- 2015 improvements: New member survey (incentivized with $50) replacing HRA
    1. The member survey can be accessed by web or by phone and doesn't require logging into a member secure portal.
    2. The survey is much shorter in length than 2014 HRA
       Items 1 and 2 should translate to higher member completion rates.
    3. The updated survey content solves for the two key hurdles for medical management intervention:
        - Specifically gathers up to date contact information so we can get in touch with the member more easily
        - Gathers high level risk stratification data (conditions, medications, etc…) to increase speed of outreach to risky members

We believe that the higher expected utilization of the new member survey, combined with the up to date contact information and high level risk stratification, will make our medical management practices more efficient and effective in 2015.

A separate change we are proposing is the impact of our revised Spend Down load, currently at 9.0% of premium. While the impact of the change to the Spend-Down population enrollment is a morbidity change rather than a change in DoHM, the DoHM lever can be used to influence utilization much in the

same way as a morbidity adjustment to the starting utilization. Due to the time constraints associated with the filing deadline, Celtic decided to alter the DoHM in order to get at the targeted rate change for both of the Spend Down change and the medical management update.

We previously assumed 6,156 Spend Down members would be enrolled in On-Exchange plans in 2015. It has come to our attention that the Healthy Indiana Plan (HIP) is scheduled to be expanded to cover individuals up to 138% of the FPL effective 1/1/2015. An adjustment for this expansion was not previously included in our Spend Down analysis due to the uncertainty of the timing of the change. Assuming the expansion takes effect 1/1/2015, this would qualify a portion of the Spend Down enrollees who would not have otherwise been eligible for coverage under HIP.

Based on the data provided in the *Spend Down Exchange Impact* report provided by the Milliman Indianapolis office, ~43% of SFY 2013 member months were for individuals in the 100%-138% of FPL bracket. Removing roughly a third of the assumed 6,156 to reflect this change and using 4,000 members instead resulted in a decrease of 4.3% to our projected Spend Down load.

In addition to the 4.3% decrease for the Spend Down revisions, we expect the medical management changes could result in savings of up to 1%-2% of premium (5.3%-6.3% in total). Recognizing the uncertainty in both of these assumptions, we have decided to reduce rates by 5% at this time.

Should you have any questions, please feel free to reach out to me.

Sincerely,

Jonathan Szerszen

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/13/2014		Supporting Document	Actuarial Memorandum and Certifications	08/19/2014	2015 Coordinated Care Corporation (IN) Actuarial Memo 20140611.pdf (Superceded)
06/13/2014		Supporting Document	Unified Rate Review Template	08/19/2014	UnifiedRateReviewSubmission_2014061314574.xml (Superceded)
06/13/2014		Supporting Document	IN State Additional Exhibits	08/19/2014	IN State Additional Exhibits 20140611.xlsb (Superceded)
06/13/2014		Supporting Document	IN Actuarial Appendices	08/19/2014	IN State Appendices 20140611.xlsb (Superceded)
06/13/2014		Rate	Rate Table Template	08/19/2014	IN State Rate Table Template 20140611.xlsm (Superceded)
05/09/2014		Supporting Document	IN State Additional Exhibits	06/13/2014	IN State Additional Exhibits 20140507.xlsb (Superceded)
05/09/2014		Supporting Document	IN Actuarial Appendices	06/13/2014	IN State Appendices 20140507.xlsb (Superceded)
05/09/2014		Rate	Rate Table Template	06/13/2014	IN State Rate Table Template 20140507.xlsx (Superceded)
05/07/2014		Form	Ambetter Secure Care 2 + Vision + Adult Dental Standard	07/30/2014	35065IN0030002-01.pdf (Superceded)
05/07/2014		Form	Ambetter Secure Care 2 + Vision + Adult Dental Zero CS	07/30/2014	35065IN0030002-02.pdf (Superceded)
05/07/2014		Form	Ambetter Secure Care 2 + Vision + Adult Dental Limited CS	07/30/2014	35065IN0030002-03.pdf (Superceded)
05/07/2014		Form	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental Standard	07/30/2014	35065IN0030004-01.pdf (Superceded)
05/07/2014		Form	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental Zero CS	07/30/2014	35065IN0030004-02.pdf (Superceded)
05/07/2014		Form	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental Limited CS	07/30/2014	35065IN0030004-03.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 3 + Vision + Adult Dental Standard	07/30/2014	35065IN0030007-01.pdf (Superceded)

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
Project Name/Number: /

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05/07/2014		Form	Ambetter Balanced Care 3 + Vision + Adult Dental Limited CS	07/30/2014	35065IN0030007-03.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 3 + Vision + Adult Dental 73% AV	07/30/2014	35065IN0030007-04.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 3 + Vision + Adult Dental 87% AV	07/30/2014	35065IN0030007-05.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 3 + Vision + Adult Dental 94% AV	07/30/2014	35065IN0030007-06.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 4 + Vision + Adult Dental Standard	07/30/2014	35065IN0030008-01.pdf (Superceded)
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05/07/2014		Form	Ambetter Balanced Care 2 + Vision + Adult Dental Standard	07/30/2014	35065IN0030014-01.pdf (Superceded)

State: Indiana **Filing Company:** Coordinated Care Corporation
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Ambetter
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05/07/2014		Form	Ambetter Balanced Care 2 + Vision + Adult Dental 73% AV	07/30/2014	35065IN0030014-04.pdf (Superceded)
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05/07/2014		Form	Ambetter Balanced Care 1 + Vision + Adult Dental Standard	07/30/2014	35065IN0030015-01.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 1 + Vision + Adult Dental Zero CS	07/30/2014	35065IN0030015-02.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 1 + Vision + Adult Dental Limited CS	07/30/2014	35065IN0030015-03.pdf (Superceded)
05/07/2014		Form	Ambetter Balanced Care 1 + Vision + Adult Dental 73% AV	07/30/2014	35065IN0030015-04.pdf (Superceded)
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05/07/2014		Form	Ambetter Balanced Care 1 + Vision + Adult Dental 94% AV	07/30/2014	35065IN0030015-06.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental Standard	07/30/2014	35065IN0030012-01.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental Zero CS	07/30/2014	35065IN0030012-02.pdf (Superceded)
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05/07/2014		Form	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental Standard	07/30/2014	35065IN0030013-01.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental Zero CS	07/30/2014	35065IN0030013-02.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental Limited CS	07/30/2014	35065IN0030013-03.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 2 + Vision + Adult Dental Standard	07/30/2014	35065IN0030016-01.pdf (Superceded)

State: *Indiana* **Filing Company:** *Coordinated Care Corporation*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Ambetter*
Project Name/Number: */*

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05/07/2014		Form	Ambetter Essential Care 2 + Vision + Adult Dental Limited CS	07/30/2014	35065IN0030016-03.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 1 + Vision + Adult Dental Standard	07/30/2014	35065IN0030017-01.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 1 + Vision + Adult Dental Zero CS	07/30/2014	35065IN0030017-02.pdf (Superceded)
05/07/2014		Form	Ambetter Essential Care 1 + Vision + Adult Dental Limtied CS	07/30/2014	35065IN0030017-03.pdf (Superceded)
05/07/2014		Form	HMO Major Medical Policy	05/30/2014	35065IN002 Final.pdf (Superceded)
05/07/2014		Form	HMO Major Medical Policy	05/30/2014	35065IN003 Final.pdf (Superceded)
05/07/2014		Form	HMO Major Medical Policy	05/30/2014	35065IN001 Final.pdf (Superceded)
05/02/2014		Supporting Document	Actuarial Memorandum and Certifications	06/13/2014	2015CoordinatedCareCorporation(IN)ActuarialMemo20140507.pdf (Superceded)
05/02/2014		Supporting Document	Unified Rate Review Template	06/13/2014	UnifiedRateReviewSubmission_20140509151046.xml (Superceded)

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Actuarial Memorandum

Coordinated Care Corporation

Individual Health Rate Filing

Effective January 1, 2015

Forms: 35065IN001, 35065IN002, 35065IN003

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1. General Information

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Coordinated Care Corporation's Individual health block of business, effective January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This actuarial memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene, parent company of Coordinated Care Corporation, and Milliman, Inc. dated January 13, 2003. This information is intended for use by the Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Coordinated Care Corporation's Individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for Coordinated Care Corporation by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions. This is a renewal rate filing. The purpose of this filing is to meet the requirements of the State of Indiana statutes and demonstrate that the benefits are reasonable in relation to the premium charged.

Company Identifying Information:

- Company Legal Name: Coordinated Care Corporation
- State: The State of Indiana has regulatory authority over these policies.
- HIOS Issuer ID: 35065
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information:

- Primary Contact Name: Jon Szerszen
- Primary Contact Telephone Number: (312) 332-8560
- Primary Contact Email Address: jszerszen@celtic-net.com

Description of Benefits:

These products are HMO health policies issued by Coordinated Care Corporation. Each plan below can be a stand-alone plan, have adult vision coverage, or have both adult vision and adult dental coverage. The major provisions of this form for each plan design and product are as follows:

Plan Design	Med Deductible	Plan Coins	Rx Deductible	OOP Max	PCP Visit	Spec Visit	Rx Copay
Ambetter Secure Care 2	$500	80%	$500	$6350	$50 NSD	$75 NSD	$15 NSD/$30 SD/$100 SD/30% SD / Max $350
Ambetter Secure Care 1 with 3 Free PCP Visits	$1000	80%	$500	$6350	D&C	D&C	$10 NSD/$25 SD/$75 SD/30% SD / Max $350
Ambetter Balanced Care 3	$2500	70%	$1000	$6350	$50 NSD	$75 NSD	$20 NSD/$50 SD/$100 SD/D&C / Max $350
Ambetter Balanced Care 4	$2000 INT	80%	INT	$6350	$50 NSD	$75 NSD	$20 NSD/$50 NSD/$100 SD/D&C
Ambetter Balanced Care 5	$3000	100%	$1000	$6350	$50 NSD	$75 NSD	$10 NSD/$50 SD/$75 SD/$250 SD
Ambetter Balanced Care 1	$5000	70%	$750	$6350	$25 NSD	$50 NSD	$10 NSD/$60 SD/50% SD/50% SD
Ambetter Balanced Care 2	$5000 INT	100%	INT	$5000	$30 NSD	$60 NSD	$10 NSD/$50 NSD/D&C/D&C
Ambetter Essential Care 2	$5000 INT	60%	INT	$6500	D&C	D&C	$25 NSD/$50 SD/$100 SD/D&C
Ambetter Essential Care 1	$6500 INT	100%	INT	$6500	D&C	D&C	$20 NSD/D&C/D&C/D&C
Ambetter Essential Care 3 with 3 Free PCP Visits	$6000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$50 SD/$100 SD/30% SD / Max $350
Ambetter Essential Care 4 with 3 Free PCP Visits	$4000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$100 SD/$150 SD/30% SD / Max $350

D&C – Deductible and Coinsurance

INT – Integrated Medical and Rx Deductible

NSD – Not subject to deductible

SD – Subject to deductible

Rx Copay – Generic / Preferred Brand / Non-Preferred Brand / Specialty

Rate Guarantees:

Rates are guaranteed not to change through December 31, 2015.

Renewability:

Each policy is renewable by paying the applicable renewal premiums unless the policy holder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability:

The rates will apply to new and renewing business.

General Marketing Method:

This product will be sold through agents, direct mailings, the internet, and the Federally Facilitated Exchange.

Estimated Average Annual Premium:

The following is a comparison of estimated average annual premium per policy:

Date	Nationwide*	Indiana
Calendar Year 2015	$5,171	$5,171

*Note that the products to which this rate filing applies are offered only in Indiana.

Distribution of Business:

See Appendix A for the expected age and geographic distributions for these products.

Rate Tables:

See Appendix B for base rate and allowable rating factors. Appendix B also includes an example of how rating factors will be applied. Note that for family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Patient Protection and Affordable Care Act (ACA).

The geographic factors are developed based upon contractual reimbursement and provider practice pattern differences in each of the established rating areas. Based upon the expected distribution of enrollment by area, the geographic factors reflect the single risk pool results consistent with the URRT. The geographic factors for unit cost and utilization differences within the manual rate model vary by Metropolitan Service Area (MSA), and are a component to the geographic factor. To the extent the established rating area is a subset of an MSA, the manual rate model geographic factors are supplemented with county specific unit cost relativities.

The age band factors are prescribed through the ACA guidance.

The tobacco factors are developed based on Milliman research and are within the 1.0 to 1.5 tobacco factor range.

Premium Modalization:

Premiums will be collected only on a monthly basis.

Trend Assumption:

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2. Proposed Rate Increase(s)

The rate increases for each product offered by Coordinated Care Corporation in the State of Indiana are reflected in Worksheet 2, Section I of the Part I URRT.

Reasons for Rate Increase(s):

The rate projections for 2015 have been updated from the previous year's projections to reflect the most recent information available.

Here is a description of the significant factors driving the proposed rate increase for 2015:

- Change in Single Risk Pool Experience

  The morbidity for the Individual market population in 2015 was estimated using the Milliman State Impact Model (SIM). There is a full description of this model in the Credibility Manual Rate Description section.

- Unit Cost Trend

  Unit costs and reimbursement agreements with providers have changed between 2014 and 2015.

- Utilization Trend

  The Milliman *Health Cost Guidelines* underlying the rate projections have been updated to reflect projected changes in utilization from 2014 to 2015. There is a full description of this model in the Credibility Manual Rate Description section.

- Prospective changes to benefits covered by the product or successor products

  The benefits covered are not expected to change during the effective period.

- New taxes and fees imposed on the issuer

  Premium rates have been adjusted to reflect the schedule of taxes and fees for 2015. While there were no new tax categories added between 2014 and 2015, the rates of the taxes changed. For the Health Insurance Provider Fee, the percentage was recalculated to reflect that the federal government plans on collecting $11.3 billion for 2015, compared to $8.0 billion for 2014. The Patient Centered Outcomes Research Fee has been increased from the 2014 amount.

- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

Assumptions for the Federal Transitional Reinsurance Program have been updated for 2015. Both the fee charged and the expected benefits will change from 2014 to 2015. Here are the specific changes in parameters from 2014 (as of the time of pricing in May 2013) to 2015:

- Claims attachment point: Changing from $60,000 to $70,000
- Reinsurance Cap: Remaining at $250,000
- Coinsurance Rate: Changing from 80% to 50%.
- Reinsurance Issuer Fee: Changing from $5.25 PMPM to $3.67 PMPM.

3. Experience Period Premium and Claims

Not applicable. At the time of this filing, data was not available.

4. Benefit Categories

The Milliman Health Cost Guidelines (HCG) were used to categorize the projected claims into the benefit categories in Worksheet 1, Section II. The detailed benefit categories from the HCGs were then consolidated into the categories shown on Worksheet 1, Section II of the Part I URRT. See Appendix C for a description of this mapping.

5. Projection Factors

Not applicable. This is a filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6. Credibility Manual Rate Development

Source and Appropriateness of Experience Data Used

Expected morbidity for the Indiana Individual market population in 2015 was estimated using the Milliman State Impact Model (SIM). The SIM is designed to model population shifts across insurance markets due to health reform and quantify the impact of these shifts on the composite morbidity for each market.

The SIM combines demographic data from the American Community Survey, the Current Population Survey, and cost data from CCIIO MLR reports in order to develop a comprehensive picture of Indiana's pre-ACA marketplace by insurance coverage (including uninsured), age, gender, income, and self-reported health status.

Morbidity factors based on two Milliman tools: the Health Cost Guidelines; and the Small Group Medical Underwriting Guidelines; are assigned to each member in the population. The morbidity factors vary based on the member's age, gender, and self-reported health status.

The impact of health reform on the Indiana insurance markets is modeled by transitioning enrollees across insurance coverage categories, assuming a static population. Modeled transitions include the following:

-Employer Plan Termination
-Voluntary Employee Termination and Early Retirement
-Uninsured Insurance Participation
-Disenrollment from the Individual Market as a Reaction to Post-ACA Community Rating
-Exchange Participation by Existing Off-Exchange Individual Insurance Enrollees
-State and Federal High Risk Pool Termination

Transition rates vary by insurance coverage, age, gender, income, and self-reported health status. Aggregate transition rates between insurance coverage pairs were initially calibrated based on aggregate transition rates from the March 2013 SOA/Optum Study "Cost of the Future Newly Insured under the Affordable Care Act (ACA)"[1], and subsequently adjusted based on implied individual Exchange enrollment rates through February 1, 2014 published in the February 12, 2014 ASPE Issue Brief "Health Insurance Marketplace: February Enrollment Report"[2].

Composite morbidity is then calculated for each pre-ACA and post-ACA insurance market based on the distribution of membership by age, gender, and self-reported health status. A Pent-Up Demand

[1] http://www.soa.org/NewlyInsured/

[2] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

adjustment is applied to the morbidity of the newly insured (those who transitioned from uninsured to insured), ranging from 2.5% for members reporting in Excellent or Very Good health to 5% for members in Good or Fair/Poor health.

The composite morbidity factors were then used to calibrate the Managed Care Rating Model (MCRM) to the projected Individual population for Indiana by scaling utilization in the model's basic tables to reflect the ratio of pre-ACA Large Group morbidity which is the MCRM base assumption to projected post-ACA Individual On-Exchange morbidity from the SIM.

The manual rate development is based on the calibrated MCRM and the companion HCGs. The MCRM includes several adjustments from the HCGs to adjust to be consistent with the expected individual population that will be enrolled for geographic area utilization relativities, expected provider reimbursement, and utilization management programs.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverage levels.

The Milliman HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

Market-wide rates were developed based on the adjusted MCRM, and we used the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

Adjustments Made to the Data

The following adjustments were made to calibrate the pricing model to the expected population:

-Rating region
-Expected demographics
-Expected morbidity
-Provider Reimbursement
-Expected utilization management savings
-Benefit plan designs

Transition from ICD9 to ICD10

Centene assumes that the coding cost impact of transitioning from ICD-9 to ICD-10 will be immaterial and is making no pricing adjustment for this transition. To make this determination, Centene reviewed several external studies and conducted an internal study. These studies priced an identical set of claims coded in both ICD-9 and ICD-10 (simulated by using General Equivalence Mappings). Although some conditions coded under ICD-10 had a higher cost than ICD-9, others had a lower cost. Centene's internal study also found that some provider's cost levels increased under ICD-10 while others decreased. After a review of all studies, Centene concluded that these positive and negative variances served to cancel each other out. Hence, the decision was made to make no adjustment for this transition.

Inclusion of Capitation Payments

Capitated payments for services are accounted for through a PMPM allocation to claims, where the average capitation amount replaces the projected claims amount.

7. Credibility of Experience

Coordinated Care Corporation does not have credible experience on which to base rate development. The product became effective on January 1, 2014. As a result of the immature claims experience and volatile membership to date, there is insufficient claims experience to support premium development. We used a credibility percentage of 0%, for the purposes of the rate projection.

8. Paid to Allowed Ratio

The Paid to Allowed Average Factor in the Projection Period for the market is shown on Worksheet 1, Section III.

This ratio was developed by compositing values from the pricing model by plan. The pricing model that develops the plan cost relativities calculates per member per month costs on both an allowed and paid basis. The paid to allowed ratios for each plan in Worksheet 2 were composited using the projected membership in Worksheet 2. This calculation is shown in Appendix D.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

The first step to developing the risk adjustment transfer payment is to summarize the projected enrollment by age, gender, plan design, and income (relative to the federal poverty level), and make estimates of each component of the risk transfer formula for each enrollment cell. These estimates are then aggregated using projected statewide and Coordinated Care Corporation enrollment to determine the portfolio average risk transfer payment or receivable, which is then proportionally allocated to all plans in the portfolio.

The risk transfer calculations are based on the risk adjustment transfer formula, as provided in the Federal Register Volume 78 Number 47, and displayed below. The "HHS Notice of Benefit and Payment Parameters for 2015", which was made final March 11, 2014, states that the 2015 risk adjustment parameters are the same as those used for the 2014 plan year.

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \overline{P_s}$$

Where:

$\bar{P}_s$= State average premium

$PLRS_t$ = plan i's plan liability risk score;

AV_i= plan i's metal level AV;

ARF_i= plan i's allowable rating factor;

IDF_i = plan i's induced demand factor;

GCF_i = plan i's geographic cost factor;

s_i = plan i's share of State enrollment as measured in member months;
and the denominator is summed across all plans in the risk pool in the market in the State.

For the purpose of our modeling, each of these factors was approximated as follows.

$\overline{P}$: For the State Average Premium, it was assumed the average statewide premium is approximately $426 PMPM.

PLRS: The risk score is approximated as the product of factors from two models:

1) Average Health and Human Services Hierarchical Condition Category (HHS-HCC) Risk Adjustment score by age and gender and metal level AV for the pre-reform Individual Market, developed using Truven Market Scan data;
2) Morbidity of the 2015 statewide Individual Market risk pool and 2015 On-Exchange population morbidity, relative to the pre-reform Individual Market average by age and gender, adjusted for the expected efficiency of the HHS-HCC Risk Adjuster

The HHS-HCC code was adapted from the published rules relating to market reform.

The previous section Credibility Manual Rate Development describes the development of the SIM enrollment and morbidity estimates, based on data and assumptions regarding the distribution of health status by insurance coverage pre-reform and insurance coverage transitions through 2015. The SIM estimates relative morbidity from each population's relative composition by age, gender, and self-reported health status.

IDF: The induced demand factors are provided in the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.

AV: The actuarial value is provided in the March 11, 2013 Federal Register, page 15433, Table 9. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold, 0.80, and Platinum 0.90.

ARF: As stated in the March 11, 2013 Federal Register, page 15433, the allowable rating factor adjustment accounts only for age rating. The adjustment uses the HHS age rating factors blended to the anticipated enrollment age band level. An equal distribution for each age within each age band was assumed.

GCF: No adjustment was assumed for the geographic rating factors.

This calculation results in an estimated per member risk adjustment relativity factor for each enrollment cell, which when multiplied by the state-wide average premium gives the estimated per member per month transfer payment. These transfer payments are then composited over enrollment for all plans to estimate the total and proportionally distributed relative to premium for each plan.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

The 2015 Transitional Reinsurance program payout parameters, applicable to members in the Individual market, are:

- $70,000 claims attachment point
- $250,000 reinsurance cap
- 50% coinsurance rate

The anticipated payments from this temporary program in 2015 are equivalent to approximately 6.9% of premium.

This estimate was derived by considering the claim probability distribution adjusted to reflect the estimated paid PMPM underlying the modified MCRM pricing model, given the payment parameters stated above. HHS will assess $3.67 PMPM to fund the transitional reinsurance program in 2015. The expected transitional reinsurance recovery is $29.69 PMPM. The net reinsurance recovery is then $26.02 PMPM and is allocated proportionally based on plan premiums across all plans.

Temporary Risk Corridor:

No adjustment was made to the Index rate due to the temporary risk corridor program. Although no adjustment was made in pricing for the risk corridor program, it is still possible that risk corridor transfer payments could be made, depending on actual experience. There is risk borne by carriers due to changes and uncertainties in the market stabilization program.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

Based on our membership projections, we have projected that we need $49.11 PMPM to cover administrative expenses. This allowance is estimated to appropriately cover expenses for overhead, operations, sales, distribution, and marketing expenses.

We have estimated an additional $1.88 PMPM to cover approved quality improvement expenses and $2.00 PMPM to cover provider incentive payments.

The administrative expenses are allocated proportionally by plan.

Profit (or Contribution to Surplus) & Risk Margin:

The proposed rates reflect 5.0% of premium as a risk/profit margin. This load was applied to all products and plans.

Taxes and Fees:

The following taxes and fees are included in the non-benefit expenses:

$2.00 Per Member Per Year for the Patient Centered Outcomes Research Fee (0.04% of Premium)
$1.00 Per Member Per Year for the Risk Adjustment User Fee (0.02% of Premium)
3.00% of premium for the Health Insurance Provider Fee
1.30% of premium for State of Indiana Premium Tax assessments
3.50% of premium for Federally Facilitated Exchange fee
0.40% of premium for anticipated assessments (high risk pool)

The Federal transitional reinsurance contribution of $3.67 PMPM is netted out of the reinsurance recoverable, as described in the previous section. It is not included as a non-benefit expense.

11. Projected Medical Loss Ratio

The projected medical loss ratio is 83.8%. This loss ratio is calculated consistently with the federal MLR methodology. See table below for the calculation.

a)	Incurred Claims	$376.19
b)	Risk Adjustment Transfer	($25.52)
c)	Transitional Reinsurance Payment	($29.69)
d)	Adjusted Incurred Claims (a+b+c)	$320.97
e)	Reinsurance Premium	$3.67
f)	Worksheet 1 Projected Incurred Claims (d+e)	$324.64
g)	Administrative Expenses	$49.11
h)	Profit and Contribution to Surplus	$21.54
i)	Taxes and Fees	$35.58
j)	Premium (f+g+h+i)	$430.88
k)	Federal Income Tax	$7.54
l)	State Income Tax	$0.84
m)	Medical Loss Ratio (d/(j-e-i-k-l))	83.8%

The expected Lifetime Loss Ratio is 75.3% [=(f) / (j)].

12. Single Risk Pool

The index rate is based on the Single Risk Pool set by the State of Indiana, which was established according to the requirements in 45 CFR Part 156.80(d). The Single Risk Pool is defined as the non-grandfathered Individual business in Indiana.

13. Index Rate

The Index Rate for the Experience Period has been left blank, since there is not credible experience on which to base the rate development.

The Index Rate for the Projection Period (calendar year 2015) is reflected in Section III, worksheet 1 of the URRT.

The Index Rate for the Projection Period represents the estimated total combined projected allowed claims PMPM for essential health benefits (EHB) for calendar year 2015, and has not been adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees. The total allowed claims include benefits in excess of EHBs (Acupuncture, Adult vision coverage, and Adult dental coverage). Pediatric dental is not included in the benefit package since this will be offered through a stand-alone plan on the Exchange. The index rate was calculated based on the results of the Credibility Manual Rate Development, detailed above. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

The development of the projection Index Rate is found in Section II of worksheet 1. The projection period Index Rate reflects:

- The 12 months projection period shown in Worksheet 1, Section II.
- The anticipated claim level of the projection period with respect to trend, benefit and demographics
- The experience of all policies expected to be in the single risk pool (with necessary adjustments)

Appendix E demonstrates the flow of the rate development from the projection Index Rate to the Consumer Adjusted Premium Rates. The next three sections further describe the steps of the rate development shown in Appendix E.

14. Market Adjusted Index Rates

The Index Rate was then adjusted to arrive at a Market Adjusted Index Rate, based on the following allowable adjustments, as outlined in 45 CFR 156.80(d):

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

The reinsurance and risk adjustments are described above in the Reinsurance and Risk Adjustment section.

The Exchange user fee is 3.5% of premium.

Appendix E shows the development of the Market Adjusted Index Rate.

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rate is the Market Adjusted Index Rate adjusted for any of the following allowable adjustments, where applicable, as outlined in 45 CFR 156.80(d):

- The actuarial value and cost-sharing design of the plan
- Provider network, delivery system and utilization management adjustment
- The benefits provided under the plan that are in addition to the essential health benefits
- Adjustment for distribution and administrative costs

Administrative costs and Other Benefits (non-EHB) common to all plans are added to the Market Adjusted Index Rate and then factors for actuarial value and cost sharing, tobacco surcharge and non-EHBs by plan are applied to reach the Plan Adjusted Index Rates by plan.

The development and values of the Plan Adjusted Index Rates are shown in Appendix E.

16. Calibration

Calibration factors reflecting the allowable rating factors are applied to the Plan Adjusted Index Rates in order to calculate the Consumer Adjusted Premium Rates. The calibration factors for each of the age factors and geographic factors are shown in Appendix E. Note that each of the calibration factors has one value that is applied uniformly and does not vary by plan.

Age Curve Calibration

The age curve calibration factor applied in Appendix E is calculated by weighting the prescribed age rating factors with the single risk pool membership distribution. The age factor for each age band is the simple average of the factors in that band. The weighted average age that corresponds to this age calibration factor is 47 years.

Appendix E of the Actuarial Memorandum demonstrates the step of applying the age calibration factor to the Plan Adjusted Index Rate to get to the Consumer Adjusted Premium Rates.

Geographic Factor Calibration

The geographic rating factors are displayed in Appendix B.

17. Consumer Adjusted Premium Rate Development

Each Plan Adjusted Index Rate is divided by the overall calibration factor to determine the Consumer Adjusted Premium Base Rate.

The following allowable rating factors, as specified by 45 CFR Part 147.102, are applied to the Consumer Adjusted Premium Base Rate to determine the rate that is charged to the health insurance purchaser:

- Rating area
- Age
- Tobacco status
- For family coverage, rates for children are charged to no more than the three oldest covered children under age 21

Appendix B lists the allowable rating factors and has an example calculation of a family's rates.

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I URRT were based on the Federal AV Calculator. Please refer to Appendix F for screen shots documenting the outcomes of the AV Calculator for each plan.

19. AV Pricing Values

For each plan, we have indicated the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). See Appendix G for this development.

Each plan's AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. The AV Pricing Values reflect the relative impact of the following items:

- The plan's provider network, delivery system characteristics and utilization management
- The actuarial value and cost sharing design of the plan
- The additional expected cost of non-essential health benefits provided under each plan
- Administrative costs, excluding Exchange user fees
- Tobacco surcharge

The benefit relativities were developed using the MCRM, as described in the Credibility Manual Rate Development section. Since these products were first offered effective 1/1/2014, and Coordinated Care Corporation does not have experience on which to base the rate development, the MCRM was used to develop the benefit relativities for the AV Pricing Values.

Market-wide rates were developed based on the MCRM using the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

20. Membership Projections

Statewide individual market enrollment projections were developed from the same State Impact Model (SIM) projections used to estimate individual market morbidity (see the "Credibility Manual Rate Development" section for more details). Coordinated Care Corporation adjusted the projections for specific expectations regarding Medicaid MCO and Health Plan market share. Specifically, adjustments were made to reflect the proportion of enrollees by income selecting a Medicaid MCO that offers individual insurance on the exchange. Of the proportion of enrollment that select a Medicaid MCO offering individual insurance, the Health Plan made assumptions regarding expected membership based on the portion of this segment in each county that is in line with its current market share of Medicaid Managed Care business in that county.

For Silver plan membership, the portion of the projected enrollment that will be eligible for cost sharing reduction subsidies at each subsidy level was based on the income level detail in the enrollment projections. The detail of the projected membership by subsidy level is shown in Appendix H.

21. Terminated Products

No products will be terminated.

22. Plan Type

Not applicable. The Plan types listed in Worksheet 2, Section I of the Part I URRT describe Coordinated Care Corporation's plans exactly.

23. Warning Alerts

There are no warning alerts in the URRT.

24. Effective Rate Review Information

The following section is provided to facilitate rate review by the Indiana Department of Insurance. The content provided follows the section "III Actuarial Memorandum" of the filing instructions named "7.0(A) Qualified Health Plans (QHPs) Individual Rate Requirements for Major Medical, HMO and Dental".

24.1. Benefit Structure

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Coordinated Care Corporation's Individual health block of business, effective January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This actuarial memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene, parent company of Coordinated Care Corporation, and Milliman, Inc. dated January 13, 2003. This information is intended for use by the Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Coordinated Care Corporation's Individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for Coordinated Care Corporation by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions. This is a renewal rate filing. The purpose of this filing is to meet the requirements of the State of Indiana statutes and demonstrate that the benefits are reasonable in relation to the premium charged.

Company Identifying Information:

- Company Legal Name: Coordinated Care Corporation
- Market: Individual
- Prior SERFF Tracking Number: CELT - 128986928

A copy of the policy form is attached as part of this filing.

The benefits provided fall into four categories:

- Essential Health Benefits: All plans provide coverage for the essential health benefits as prescribed through ACA guidance and as covered by the benchmark plan for Indiana.
- State Mandated Benefits Which are Not Essential Health Benefits: There are no state mandated benefits which are not essential health benefits.
- Additional Mandatory Supplemental Benefits: The plans offered under this filing do not include any additional mandatory supplemental benefits.
- Additional Optional Supplemental Benefits: Each medical plan design, as described below, is available with adult vision coverage or with adult vision and adult dental coverage.

This rate filing proposes changes to the previous filing for the base rate, rating factors, non-benefit expenses and the plans offered. The covered benefits have not changed from the previous filing.

These products are HMO health policies issues by Coordinated Care Corporation. Each plan below can be a stand-alone plan, have adult vision coverage, or have both adult vision and adult dental coverage. The major provisions of this form for each plan design and product are as follows:

Plan Design	Med Deductible	Plan Coins	Rx Deductible	OOP Max	PCP Visit	Spec Visit	Rx Copay
Ambetter Secure Care 2	$500	80%	$500	$6350	$50 NSD	$75 NSD	$15 NSD/$30 SD/$100 SD/30% SD / Max $350
Ambetter Secure Care 1 with 3 Free PCP Visits	$1000	80%	$500	$6350	D&C	D&C	$10 NSD/$25 SD/$75 SD/30% SD / Max $350
Ambetter Balanced Care 3	$2500	70%	$1000	$6350	$50 NSD	$75 NSD	$20 NSD/$50 SD/$100 SD/D&C / Max $350
Ambetter Balanced Care 4	$2000 INT	80%	INT	$6350	$50 NSD	$75 NSD	$20 NSD/$50 NSD/$100 SD/D&C
Ambetter Balanced Care 5	$3000	100%	$1000	$6350	$50 NSD	$75 NSD	$10 NSD/$50 SD/$75 SD/$250 SD
Ambetter Balanced Care 1	$5000	70%	$750	$6350	$25 NSD	$50 NSD	$10 NSD/$60 SD/50% SD/50% SD
Ambetter Balanced Care 2	$5000 INT	100%	INT	$5000	$30 NSD	$60 NSD	$10 NSD/$50 NSD/D&C/D&C
Ambetter Essential Care 2	$5000 INT	60%	INT	$6500	D&C	D&C	$25 NSD/$50 SD/$100 SD/D&C
Ambetter Essential Care 1	$6500 INT	100%	INT	$6500	D&C	D&C	$20 NSD/D&C/D&C/D&C
Ambetter Essential Care 3 with 3 Free PCP Visits	$6000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$50 SD/$100 SD/30% SD / Max $350
Ambetter Essential Care 4 with 3 Free PCP Visits	$4000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$100 SD/$150 SD/30% SD / Max $350

D&C – Deductible and Coinsurance

INT – Integrated Medical and Rx Deductible

NSD – Not subject to deductible

SD – Subject to deductible

Rx Copay – Generic / Preferred Brand / Non-Preferred Brand / Specialty

24.2. Current Rates

The current rates are attached in the form of the 2014 Federal Rate Template. Premiums are collected only on a monthly basis. The current rates do not change during the rating period. The current geographic rating factors are consistent with the expected unit cost differences between areas. The current rates are charged on an individual basis. For family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Affordable Care Act. The policyholder's premium payment under the current rates is impacted by the following factors:

- Geography
- Tobacco
- Age
- Plan Design

24.3. Proposed Rates

The proposed rates are attached in the form of the 2015 Federal Rate Template. Premiums will be collected only on a monthly basis. The proposed rates do not change during the rating period. The geographic factors are developed based upon contractual reimbursement differences and expected utilization differences in each of the established rating areas. Based upon the expected distribution of enrollment by area, the geographic factors reflect the single risk pool results consistent with the URRT. The geographic factors for unit cost and utilization differences within the manual rate model vary by Metropolitan Service Area (MSA), and are a component to the geographic factor. To the extent the established rating area is a subset of an MSA, the manual rate model geographic factors are supplemented with county specific unit cost relativities. The attached rate schedule is reflective of the geographic rating factors. The proposed rates are charged on an individual basis. For family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Affordable Care Act. The policyholder's premium payment under the current rates is impacted by the following factors:

- Geography
- Tobacco
- Age
- Plan Design

The policyholder's premium payment under the proposed rates is not impacted by changes in morbidity, additional mandates, or other factors.

24.4. Projected Experience with Requested Rate Change
Appendix K.1 demonstrates the projected experience with the requested rate change.

24.5. Projected Experience without Requested Rate Change
Appendix K.2 demonstrates the projected experience without the requested rate change.

24.6. Assumptions
The annual per individual rate of medical cost increase assumed for the next year is equal to 3.0%. The annual per individual rate of premium increase assumed for the next year is equal to -3.2%.

24.7. Premium Guarantee Provision
The proposed rates are guaranteed not to change through December 31, 2015.

24.8. Rating Factors
In accordance with the Affordable Care Act, rates may vary by age, geographic area, tobacco use and benefit plan. Rates are charged on an individual basis. For family coverage, rates for children are charged for no more than the three oldest covered children under age 21. Appendix B includes the base rate and allowable rating factors.

Administrative Expense Load: Based on our membership projections, we have projected that we need $49.11 PMPM to cover administrative expenses. This allowance is estimated to appropriately cover expenses for overhead, operations, sales, distribution, and marketing expenses.

We have estimated an additional $1.88 PMPM to cover approved quality improvement expenses and $2.00 PMPM to cover provider incentive payments.

The administrative expenses are allocated proportionally by plan.

Profit (or Contribution to Surplus) & Risk Margin: The proposed rates reflect 5.0% of premium as a risk/profit margin. This load was applied to all products and plans.

The following taxes and fees are included in the non-benefit expenses:

$2.00 Per Member Per Year for the Patient Centered Outcomes Research Fee (0.04% of Premium)
$1.00 Per Member Per Year for the Risk Adjustment User Fee (0.02% of Premium)
3.00% of premium for the Health Insurance Provider Fee
1.30% of premium for State of Indiana Premium Tax assessments
3.50% of premium for Federally Facilitated Exchange fee
0.40% of premium for anticipated assessments (high risk pool)

The Federal transitional reinsurance contribution of $3.67 PMPM is netted out of the reinsurance recoverable, as described in the previous section. It is not included as a non-benefit expense.

The impact of contractual agreements with health care providers and administrators is factored into the geographic area factors.

24.9. Historical Experience

Note that the products to which this rate filing applies were initially offered effective 1/1/2014. As a result, experience data is limited. The following table reflects the available membership and premium data available, through 2/28/2014.

Month	Membership	Premium Revenue
1/2014	179	$90,721
2/2014	251	$126,860

24.10. Projection of Lifetime Target Loss Ratio

The target loss ratio is projected over the next five years and beyond in the exhibit, 'Projection of Lifetime Target Loss Ratio'. Note that experience period data is not available due to the current benefits being offered for the first time on 1/1/2014. The first policy year refers to 2015. Note that proposed rates are resubmitted each year, so the actual expected future lifetime of the policies affected is only one year.

24.11. Company Financial Position

See Appendix I for documents summarizing the capital and surplus position of Coordinated Care Corporation.

25. Reliance

In the preparation of this filing, I relied upon data provided under the direction of Charles Kearns, Centene. I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

See Appendix J for a listing of items received for the rate development.

26. Actuarial Certification

I, Jason T. Nowakowski, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This filing is prepared on behalf of Coordinated Care Corporation (the "Company") to comply with applicable State and Federal Statutes for Individual Rate Filings.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I certify that this filing has been prepared in accordance with the following:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

I certify that the projected Index Rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Actuarially sound and developed in compliance with the applicable Actuarial Standards of Practice. For the purposes of this certification, actuarially sound is defined as, in consideration of expected reinsurance cash flows, risk adjustment cash flows, and investment income, containing adequate provision for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the essential health benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans. The AV Metal Values included in Worksheet 2 in Part I URRT were based on the Federal AV Calculator.

I certify that rates are charged to no more than the three oldest covered children under 21 for a family coverage.

I certify that, to the best of my knowledge and understanding, the proposed rates are in compliance with requirements under 45 CFR Subpart E (Section 156.400 through 156.470) and Coordinated Care Corporation intends to use the methodology outlined by HHS for advanced Cost-Sharing Reduction payments.

The Part I URRT does not demonstrate the process used by Coordinated Care Corporation to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

I certify that this rate filing was prepared in compliance with all applicable state and federal statutes and regulations.

I certify that this rate filing was prepared in compliance with Actuarial Standards of Practice (ASOP).

Signed: Jason T. Nowakowski

Name: Jason T. Nowakowski

Title: Principal & Consulting Actuary

Date: June 11, 2014

Appendix A
Coordinated Care Corporation
Age and Rating Area Distributions

Age Band	Percent Distribution
0-20	7.24%
21	1.44%
22	1.44%
23	1.44%
24	1.44%
25	2.08%
26	2.08%
27	2.08%
28	2.08%
29	2.08%
30	2.07%
31	2.07%
32	2.07%
33	2.07%
34	2.07%
35	2.16%
36	2.16%
37	2.16%
38	2.16%
39	2.16%
40	2.24%
41	2.24%
42	2.24%
43	2.24%
44	2.24%
45	2.21%
46	2.21%
47	2.21%
48	2.21%
49	2.21%
50	2.00%
51	2.00%
52	2.00%
53	2.00%
54	2.00%
55	2.49%
56	2.49%
57	2.49%
58	2.49%
59	2.49%
60	2.15%
61	2.15%
62	2.15%
63	2.15%
64	2.15%
65 and Over	0.00%

Rating Area	Percent Distribution
Rating Area 1	15.5%
Rating Area 2	8.7%
Rating Area 3	6.9%
Rating Area 4	8.6%
Rating Area 6	2.8%
Rating Area 10	39.7%
Rating Area 11	7.8%
Rating Area 13	3.4%
Rating Area 15	3.2%
Rating Area 16	3.3%

Appendix B
Coordinated Care Corporation
Rate Table

Base Rate	$280.74

Product Adjustment	
Product	PMPM Adj
35065IN001 (Appies to all plans)	$0.00
35065IN002 (Appies to all plans)	$4.66
35065IN003 (Appies to all plans)	$16.33

Plan	Rate Factor
Ambetter Secure Care 2	1.168
Ambetter Secure Care 1 with 3 Free PCP Visits	1.150
Ambetter Balanced Care 3	0.998
Ambetter Balanced Care 4	0.972
Ambetter Balanced Care 5	1.000
Ambetter Balanced Care 1	0.962
Ambetter Balanced Care 2	0.924
Ambetter Essential Care 2	0.766
Ambetter Essential Care 1	0.755
Ambetter Essential Care 3 with 3 Free PCP Visits	0.769
Ambetter Essential Care 4 with 3 Free PCP Visits	0.801

Age Band	Age Factor	Tobacco Factors	
		Smoker	Non-Smoker
0-20	0.635	1.155	1.000
21	1.000	1.155	1.000
22	1.000	1.155	1.000
23	1.000	1.155	1.000
24	1.000	1.155	1.000
25	1.004	1.085	1.000
26	1.024	1.085	1.000
27	1.048	1.085	1.000
28	1.087	1.085	1.000
29	1.119	1.085	1.000
30	1.135	1.085	1.000
31	1.159	1.085	1.000
32	1.183	1.085	1.000
33	1.198	1.085	1.000
34	1.214	1.085	1.000
35	1.222	1.055	1.000
36	1.230	1.055	1.000
37	1.238	1.055	1.000
38	1.246	1.055	1.000
39	1.262	1.055	1.000
40	1.278	1.102	1.000
41	1.302	1.132	1.000
42	1.325	1.162	1.000
43	1.357	1.192	1.000
44	1.397	1.222	1.000
45	1.444	1.172	1.000
46	1.500	1.212	1.000
47	1.563	1.252	1.000
48	1.635	1.292	1.000
49	1.706	1.332	1.000
50	1.786	1.455	1.000
51	1.865	1.415	1.000
52	1.952	1.375	1.000
53	2.040	1.335	1.000
54	2.135	1.295	1.000
55	2.230	1.250	1.000
56	2.333	1.225	1.000
57	2.437	1.200	1.000
58	2.548	1.175	1.000
59	2.603	1.150	1.000
60	2.714	1.120	1.000
61	2.810	1.105	1.000
62	2.873	1.090	1.000
63	2.952	1.075	1.000
64	3.000	1.060	1.000
65 and Over	3.000	1.060	1.000

Geographic Factors	
Area	Rate Factor
Rating Area 1	0.947
Rating Area 2	1.101
Rating Area 3	0.910
Rating Area 4	0.869
Rating Area 6	0.972
Rating Area 10	1.051
Rating Area 11	1.098
Rating Area 13	1.199
Rating Area 15	0.860
Rating Area 16	0.625

Appendix B
Coordinated Care Corporation
Rating Example

Family Rating Example

Plan Design:	Ambetter Secure Care 2
Product:	35065IN001

				(a)	(b)	(c)	(d) = ((a) + (b)) x (c)	(e)	(f)	(g)	(h) = (d) x (e) x (f) x (g)
Member	**Age**	**Smoking Status**	**Rating Area**	**Base**	**Prod. Adj.**	**Plan Rate Factor**	**Consumer Adjusted Premium Rate**	**Age Factor**	**Tobacco**	**Area**	**Final Premium**
Subscriber	40	Non-Smoker	Rating Area 1	$280.74	$0.00	1.168	$327.90	1.278	1.000	0.947	$396.85
Spouse	38	Non-Smoker	Rating Area 1	280.74	0.00	1.168	327.90	1.246	1.000	0.947	386.91
Child 1	18	Non-Smoker	Rating Area 1	280.74	0.00	1.168	327.90	0.635	1.000	0.947	197.18
Child 2	16	Non-Smoker	Rating Area 1	280.74	0.00	1.168	327.90	0.635	1.000	0.947	197.18
Child 3	14	Non-Smoker	Rating Area 1	280.74	0.00	1.168	327.90	0.635	1.000	0.947	197.18
Child 4	11	Non-Smoker	Rating Area 1	280.74	0.00	1.168	327.90	0.000	1.000	0.947	0.00
Total											**$1,375.32**

(1) Look up the plan rate factor based on the plan design.
(2) Multiply the plan's base rate by the plan rate factor to calculate the Consumer Adjusted Premium Rate.
(3) Look up the age factors for each member based on age.
Note that premiums can only be charged for the first 3 children, so the age factor for all subsequent children will be 0.
(4) Look up the tobacco factor for each member according to smoking status and age.
(5) Look up the area factor based on the rating area.
(6) Multiply the Consumer Adjusted Premium Rate by the age, tobacco and area factors for each member individually.
(7) Sum the results from (6) for the final premium for the family.

Appendix C
Coordinated Care Corporation
Benefit Category Mapping

MCRM Benefit Category	URRT Benefit Category
Inpatient Facility - Non-Maternity	
Medical	Inpatient Hospital
Medical - Other Newborn	Inpatient Hospital
Surgical	Inpatient Hospital
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Inpatient Facility - Maternity	
Deliveries	Inpatient Hospital
Non-Deliveries	Inpatient Hospital
Skilled Nursing Facility	Inpatient Hospital
Outpatient Facility	
Emergency Room	Outpatient Hospital
Surgery	Outpatient Hospital
Radiology	
Radiology - General	Outpatient Hospital
Radiology - CT / MRI / PET	Outpatient Hospital
Pathology/Lab	Outpatient Hospital
Pharmacy	Outpatient Hospital
Cardiovascular	Outpatient Hospital
PT/OT/ST	Outpatient Hospital
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Preventive	Outpatient Hospital
Other Outpatient Facility	Outpatient Hospital
Professional	
Inpatient Surgery - Non-Maternity	
Surgeon	Professional
Anesthesia	Professional
Maternity	
Non-Anesthesia	Professional
Anesthesia	Professional
Outpatient Surgery	
Outpatient Facility	Professional
Office	Professional
Anesthesia	Professional
Inpatient Visits	
Medical	Professional
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Office Visits & Miscellaneous Services	
Office/Home Visits	Professional
Urgent Care Visits	Professional
Office Administered Drugs	Professional
Allergy Testing	Professional

Appendix C
Coordinated Care Corporation
Benefit Category Mapping

MCRM Benefit Category	URRT Benefit Category
Allergy Immunotherapy	Professional
Miscellaneous Medical	Professional
Preventive Services	
Immunizations	Professional
Well Baby Exams	Professional
Physical Exams	Professional
Other Preventive	Professional
Other Professional Services	
ER Visits and Observation Care	Professional
Consults	Professional
Vision Exams	Professional
Hearing and Speech Exams	Professional
Physical Therapy	Professional
Cardiovascular	Professional
Radiology	
Inpatient	Professional
Outpatient	
Outpatient - General	Professional
Outpatient - CT / MRI / PET	Professional
Office	
Office - General	Professional
Office - CT / MRI / PET	Professional
Pathology/Lab	
Inpatient & Outpatient	Professional
Office	Professional
Chiropractor	Professional
Outpatient Psychiatric	Capitation
Outpatient Alcohol & Drug Abuse	Capitation
Other	
Prescription Drugs	Prescription Drug
Private Duty Nursing/Home Health	Other Medical
Ambulance	Other Medical
DME and Supplies	Other Medical
Prosthetics	Other Medical
OptiCare - Child - Exam / Hardware	Capitation
OptiCare - Child - Med / Surg	Capitation
OptiCare - Adult - Med / Surg	Capitation
Cenpatico	Capitation
Nurtur	Capitation
Nursewise	Capitation
Teladoc	Capitation
Start Smart	Capitation
Acupuncture	Professional
Habilitation Services	Professional

Appendix D
Coordinated Care Corporation
Development of Paid to Allowed Ratio

Product	Plan Name	PlanID	(a) Member Months	(b) Allowed Claims PMPM	(c) Paid Claims PMPM	(d) = (c) / (b) Paid to Allowed Ratio
		Aggregate	**147,869**	**$527.59**	**$372.31**	**0.706**
Ambetter	Ambetter Secure Care 2	35065IN0010002	1,472	$548.74	$447.17	0.815
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	490	553.33	441.23	0.797
Ambetter	Ambetter Balanced Care 3	35065IN0010007	2,366	529.55	395.05	0.746
Ambetter	Ambetter Balanced Care 4	35065IN0010008	8,307	520.53	373.20	0.717
Ambetter	Ambetter Balanced Care 5	35065IN0010009	7,099	527.19	394.28	0.748
Ambetter	Ambetter Balanced Care 1	35065IN0010015	11,076	532.07	391.56	0.736
Ambetter	Ambetter Balanced Care 2	35065IN0010014	18,473	536.66	369.99	0.689
Ambetter	Ambetter Essential Care 2	35065IN0010016	3,686	462.62	287.17	0.621
Ambetter	Ambetter Essential Care 1	35065IN0010017	5,898	467.38	283.06	0.606
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	3,686	463.76	288.40	0.622
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	1,474	470.22	300.35	0.639
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	264	$554.33	$452.76	0.817
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	88	558.93	446.83	0.799
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	551	535.11	400.61	0.749
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	1,794	526.09	378.76	0.720
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	1,651	532.75	399.84	0.751
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	2,667	537.63	397.11	0.739
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	4,341	542.21	375.54	0.693
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	749	468.15	292.70	0.625
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	1,199	472.91	288.59	0.610
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	749	469.29	293.93	0.626
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	300	475.75	305.88	0.643
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1,181	$569.22	$467.65	0.822
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	394	573.80	461.71	0.805
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	2,692	549.89	415.40	0.755
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	8,571	540.87	393.55	0.728
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	8,079	547.54	414.63	0.757
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	13,199	552.40	411.88	0.746
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	21,325	556.97	390.30	0.701
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	3,512	482.87	307.42	0.637
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	5,619	487.63	303.30	0.622
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	3,512	484.01	308.65	0.638
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	1,405	490.49	320.62	0.654

Appendix E
Coordinated Care Corporation
Index Rate to Base Rate

			Notes
(a)	**Projected Index Rate PMPM**	$517.50	Total EHB Allowed Charges (Index Rate)
	Market Adjustments		
(b)	Net Risk Adjustment Transfer Paid/(Received)	($25.44)	Includes Risk Adjustment Admin Fee.
(c)	Net Transitional Reinsurance Payment/(Received)	(25.34)	Total composite reinsurance impact on claims, net of reinsurance premium ($3.67).
(d)	Exchange User Fees	14.65	
(e) = (a) + .. + (d)	**Market Adjusted Index Rate**	$481.37	
	Plan Adjustments		
(f)	Member Cost Sharing	($86.57)	
(g)	Silver Plan Cost Sharing Reduction Subsidy	(68.71)	
(h)	SG&A	51.69	
(i)	Profit Margin	12.79	Assumption: 5% profit margin before Federal and State Income Taxes. This does not include the $0.38 profit margin on buy-ups.
(j)	Licensing, Taxes and Fees	27.98	
(k)	Other Benefits Common to All Plans	-	
(l) = (e) + ... + (k)	**Index Rate before Plan Factor Adjustment**	$418.55	

Plan ID	Plan Name	*(1)* Member Months	*(2) = (l)* Index Rate before Plan Factor Adj	*(3)* Actuarial Value and Cost Sharing Adjustment	*(4)* Non-EHB Adjustment [1]	*(5)* Tobacco Surcharge	*(6) = (2) * (3) * (4) * (5)* Plan Adjusted Index Rate	*(7) = (t)* Calibration	*(8) = (6) / (7)* Consumer Adjusted Premium Rate
35065IN0010002	Ambetter Secure Care 2	1,472	$418.55	1.268	1.000	0.987	$524.11	1.599	$327.82
35065IN0010004	Ambetter Secure Care 1 with 3 Free PCP Visits	490	418.55	1.249	1.000	0.987	516.05	1.599	322.78
35065IN0010007	Ambetter Balanced Care 3	2,366	418.55	1.084	1.000	0.987	447.91	1.599	280.16
35065IN0010008	Ambetter Balanced Care 4	8,307	418.55	1.056	1.000	0.987	436.20	1.599	272.84
35065IN0010009	Ambetter Balanced Care 5	7,099	418.55	1.086	1.000	0.987	448.84	1.599	280.74
35065IN0010015	Ambetter Balanced Care 1	11,076	418.55	1.045	1.000	0.987	431.59	1.599	269.95
35065IN0010014	Ambetter Balanced Care 2	18,473	418.55	1.004	1.000	0.987	414.68	1.599	259.37
35065IN0010016	Ambetter Essential Care 2	3,686	418.55	0.832	1.000	0.987	343.65	1.599	214.95
35065IN0010017	Ambetter Essential Care 1	5,898	418.55	0.820	1.000	0.987	338.80	1.599	211.91
35065IN0010012	Ambetter Essential Care 3 with 3 Free PCP Visits	3,686	418.55	0.835	1.000	0.987	345.20	1.599	215.92
35065IN0010013	Ambetter Essential Care 4 with 3 Free PCP Visits	1,474	418.55	0.870	1.000	0.987	359.66	1.599	224.96
35065IN0020002	Ambetter Secure Care 2 + Vision	264	418.55	1.268	1.014	0.987	531.45	1.599	332.41
35065IN0020004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	88	418.55	1.249	1.014	0.987	523.36	1.599	327.35
35065IN0020007	Ambetter Balanced Care 3 + Vision	551	418.55	1.084	1.016	0.987	454.99	1.599	284.59
35065IN0020008	Ambetter Balanced Care 4 + Vision	1,794	418.55	1.056	1.016	0.987	443.25	1.599	277.25
35065IN0020009	Ambetter Balanced Care 5 + Vision	1,651	418.55	1.086	1.016	0.987	455.93	1.599	285.18
35065IN0020015	Ambetter Balanced Care 1 + Vision	2,667	418.55	1.045	1.016	0.987	438.62	1.599	274.35
35065IN0020014	Ambetter Balanced Care 2 + Vision	4,341	418.55	1.004	1.017	0.987	421.66	1.599	263.74
35065IN0020016	Ambetter Essential Care 2 + Vision	749	418.55	0.832	1.020	0.987	350.37	1.599	219.15
35065IN0020017	Ambetter Essential Care 1 + Vision	1,199	418.55	0.820	1.020	0.987	345.51	1.599	216.11
35065IN0020012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	749	418.55	0.835	1.019	0.987	351.92	1.599	220.12
35065IN0020013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	300	418.55	0.870	1.019	0.987	366.42	1.599	229.19
35065IN0030002	Ambetter Secure Care 2 + Vision + Adult Dental	1,181	418.55	1.268	1.049	0.987	549.86	1.599	343.93
35065IN0030004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	394	418.55	1.249	1.050	0.987	541.68	1.599	338.81
35065IN0030007	Ambetter Balanced Care 3 + Vision + Adult Dental	2,692	418.55	1.084	1.055	0.987	472.74	1.599	295.69
35065IN0030008	Ambetter Balanced Care 4 + Vision + Adult Dental	8,571	418.55	1.056	1.057	0.987	460.93	1.599	288.30
35065IN0030009	Ambetter Balanced Care 5 + Vision + Adult Dental	8,079	418.55	1.086	1.055	0.987	473.71	1.599	296.30
35065IN0030015	Ambetter Balanced Care 1 + Vision + Adult Dental	13,199	418.55	1.045	1.057	0.987	456.25	1.599	285.38
35065IN0030014	Ambetter Balanced Care 2 + Vision + Adult Dental	21,325	418.55	1.004	1.059	0.987	439.18	1.599	274.70
35065IN0030016	Ambetter Essential Care 2 + Vision + Adult Dental	3,512	418.55	0.832	1.068	0.987	367.18	1.599	229.66
35065IN0030017	Ambetter Essential Care 1 + Vision + Adult Dental	5,619	418.55	0.820	1.069	0.987	362.32	1.599	226.62
35065IN0030012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	3,512	418.55	0.835	1.068	0.987	368.73	1.599	230.64
35065IN0030013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	1,405	418.55	0.870	1.066	0.987	383.36	1.599	239.79
Total		147,869	$418.55	1.000	1.030	0.987	$425.36	1.599	$266.05

(m) = (8)	Consumer Adjusted Index Rate	$266.05	
(n)	Composite Plan Factor	0.948	
(o)	Interaction [2]	1.000	
(p) = ((m) / (n)) * (o)	**Base Rate (= Appendix B.1 "Base Rate")**	$280.74	
	Calibration		
(q)	Composite Area Factor	1.000	
(r)	Composite Age Factor	1.598	The weighted average age is 47.
(s)	Interaction [3]	1.000	
(t) = (q) * (r) * (s)	**Calibration**	1.599	

Notes:
(1) Non-EHB Adjustment includes impacts to SG&A and profit margin due to offering Adult Vision.
(2) The interaction term accounts for the interdependence of the tobacco and plan factors (EHB and Non-EHB).
(3) The interaction term accounts for the interdependence of the area, age, tobacco and plan factors.

Appendix F
Coordinated Care Corporation
AV Calculator Results

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.3%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.88%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	70.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.87%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$150.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	95.00%	70.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$2.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$5.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.46%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.67%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.85%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.90%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$100.00			
Coinsurance (%, Insurer's Cost Share)			95.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☐	☐		$5.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.79%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$250.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$150.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.2%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$10.00	☑	☑		
Skilled Nursing Facility	☑	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	97%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.97%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$25.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	97%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$100.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$750.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.49%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$1,750.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%	
OOP Maximum ($)	$5,200.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.90%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$150.00	$150.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%	
OOP Maximum ($)	$2,250.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.81%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$750.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.77%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$5,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.65%
Metal Tier:	Silver

Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.75%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☑		$1.00	☑	☑		
Preferred Brand Drugs	☐	☑		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.65%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.81%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.89%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.24%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.57%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$150.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.64%
Metal Tier:	Bronze

Appendix G
Coordinated Care Corporation
AV Pricing Value Allocation

Product	Plan Name	PlanID	Pricing AV	Provider Network, Delivery System and Utilization Management	Actuarial Value and Cost Sharing Adjustment	Non-EHB Benefits	Tobacco Surcharge	Administrative Cost
Ambetter	Ambetter Secure Care 2	35065IN0010002	1.089	1.000	0.859	1.000	0.987	1.284
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	1.072	1.000	0.846	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 3	35065IN0010007	0.930	1.000	0.734	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 4	35065IN0010008	0.906	1.000	0.715	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 5	35065IN0010009	0.932	1.000	0.736	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 1	35065IN0010015	0.897	1.000	0.708	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 2	35065IN0010014	0.861	1.000	0.680	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 2	35065IN0010016	0.714	1.000	0.563	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 1	35065IN0010017	0.704	1.000	0.555	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	0.717	1.000	0.566	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	0.747	1.000	0.590	1.000	0.987	1.284
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	1.104	1.000	0.859	1.014	0.987	1.284
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	1.087	1.000	0.846	1.014	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	0.945	1.000	0.734	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	0.921	1.000	0.715	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	0.947	1.000	0.736	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	0.911	1.000	0.708	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	0.876	1.000	0.680	1.017	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	0.728	1.000	0.563	1.020	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	0.718	1.000	0.555	1.020	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	0.731	1.000	0.566	1.019	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	0.761	1.000	0.590	1.019	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1.142	1.000	0.859	1.049	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	1.125	1.000	0.846	1.050	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	0.982	1.000	0.734	1.055	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	0.958	1.000	0.715	1.057	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	0.984	1.000	0.736	1.055	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	0.948	1.000	0.708	1.057	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	0.912	1.000	0.680	1.059	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	0.763	1.000	0.563	1.068	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	0.753	1.000	0.555	1.069	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	0.766	1.000	0.566	1.068	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	0.796	1.000	0.590	1.066	0.987	1.284

Appendix H
Coordinated Care Corporation
Membership Projections

			Member Months						
				Silver Plan					
Product	**Plan Name**	**Plan ID**	**Gold**	**70%**	**73%**	**87%**	**94%**	**Bronze**	**Total**
		Aggregate	**3,889**	**12,966**	**11,240**	**39,246**	**48,739**	**31,789**	**147,869**
Ambetter	Ambetter Secure Care 2	35065IN0010002	1,472	-	-	-	-	-	1,472
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	490	-	-	-	-	-	490
Ambetter	Ambetter Balanced Care 3	35065IN0010007	-	328	278	785	975	-	2,366
Ambetter	Ambetter Balanced Care 4	35065IN0010008	-	1,969	2,224	3,139	975	-	8,307
Ambetter	Ambetter Balanced Care 5	35065IN0010009	-	985	834	2,355	2,925	-	7,099
Ambetter	Ambetter Balanced Care 1	35065IN0010015	-	657	834	4,710	4,875	-	11,076
Ambetter	Ambetter Balanced Care 2	35065IN0010014	-	2,626	1,390	4,710	9,747	-	18,473
Ambetter	Ambetter Essential Care 2	35065IN0010016	-	-	-	-	-	3,686	3,686
Ambetter	Ambetter Essential Care 1	35065IN0010017	-	-	-	-	-	5,898	5,898
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	-	-	-	-	-	3,686	3,686
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	-	-	-	-	-	1,474	1,474
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	264	-	-	-	-	-	264
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	88	-	-	-	-	-	88
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	-	59	52	196	244	-	551
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	-	352	413	785	244	-	1,794
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	-	176	155	589	731	-	1,651
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	-	117	155	1,177	1,218	-	2,667
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	-	469	258	1,177	2,437	-	4,341
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	-	-	-	-	-	749	749
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	-	-	-	-	-	1,199	1,199
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	-	-	-	-	-	749	749
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	-	-	-	-	-	300	300
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1,181	-	-	-	-	-	1,181
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	394	-	-	-	-	-	394
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	-	261	232	981	1,218	-	2,692
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	-	1,569	1,859	3,925	1,218	-	8,571
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	-	784	697	2,943	3,655	-	8,079
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	-	523	697	5,887	6,092	-	13,199
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	-	2,091	1,162	5,887	12,185	-	21,325
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	-	-	-	-	-	3,512	3,512
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	-	-	-	-	-	5,619	5,619
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	-	-	-	-	-	3,512	3,512
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	-	-	-	-	-	1,405	1,405

Appendix I
Coordinated Care Corporation
Capital, Surplus and RBC

ASSETS

	Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1. Bonds (Schedule D)	71,141,230		71,141,230	42,130,488
2. Stocks (Schedule D):				
2.1 Preferred stocks	0		0	0
2.2 Common stocks	10,013,713		10,013,713	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5. Cash ($ 43,301,901 , Schedule E-Part 1), cash equivalents ($ 0 , Schedule E-Part 2) and short-term investments ($ 44,427,016 , Schedule DA)	87,728,917		87,728,917	88,176,976
6. Contract loans (including $ ..... premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)	1,653,392		1,653,392	1,299,177
9. Receivables for securities			0	5,000
10. Securities lending reinvested collateral assets (Schedule DL)			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	170,537,252	0	170,537,252	131,611,641
13. Title plants less $ ..... charged off (for Title insurers only)			0	0
14. Investment income due and accrued	473,403		473,403	464,665
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	4,882,895		4,882,895	11,897,969
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums			0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	1,209,054		1,209,054	745,177
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans			0	0
18.1 Current federal and foreign income tax recoverable and interest thereon			0	0
18.2 Net deferred tax asset	5,403,936		5,403,936	3,710,600
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software			0	0
21. Furniture and equipment, including health care delivery assets ($ .....)			0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	2,392		2,392	67,257
24. Health care ($ 106,095) and other amounts receivable	809,520	703,425	106,095	41,976
25. Aggregate write-ins for other than invested assets	5,778,278	122,933	5,655,345	5,553,078
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	189,096,730	826,358	188,270,372	154,092,363
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	189,096,730	826,358	188,270,372	154,092,363
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. Prepaid Expenses	122,933	122,933	0	0
2502. Company-owned life insurance	5,346,469		5,346,469	5,223,255
2503. State Income tax receivable	308,876		308,876	329,823
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	5,778,278	122,933	5,655,345	5,553,078

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	Current Year 2 Uncovered	Current Year 3 Total	Prior Year 4 Total
1. Claims unpaid (less $ 2,261,521 reinsurance ceded)	66,623,379		66,623,379	52,689,614
2. Accrued medical incentive pool and bonus amounts	6,726,935		6,726,935	2,946,531
3. Unpaid claims adjustment expenses	1,121,000		1,121,000	1,150,000
4. Aggregate health policy reserves, including the liability of $ for medical loss ratio rebate per the Public Health Service Act	8,164,161		8,164,161	4,679,976
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance	25,438,117		25,438,117	23,291,195
9. General expenses due or accrued	6,125,364		6,125,364	14,290,652
10.1 Current federal and foreign income tax payable and interest thereon (including $ on realized capital gains (losses))	3,151,891		3,151,891	3,937,398
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others			0	0
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ current) and interest thereon $ (including $ current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	776,471		776,471	142,708
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ authorized reinsurers, $ unauthorized reinsurers and $ certified reinsurers)			0	0
20. Reinsurance in unauthorized and certified ($) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ current)	13,045,633	0	13,045,633	7,742
24. Total liabilities (Lines 1 to 23)	131,172,951	0	131,172,951	103,135,816
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	545,000	545,000
27. Preferred capital stock	XXX	XXX		0
28. Gross paid in and contributed surplus	XXX	XXX	21,700,000	21,700,000
29. Surplus notes	XXX	XXX		0
30. Aggregate write-ins for other-than-special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	34,852,421	28,711,547
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 $)	XXX	XXX		0
32.2 shares preferred (value included in Line 27 $)	XXX	XXX		0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	57,097,421	50,956,547
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	188,270,372	154,092,363
DETAILS OF WRITE-INS				
2301. State Income Tax Payable			0	7,742
2302. Washington Premium Adjustment	13,045,633		13,045,633	
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	13,045,633	0	13,045,633	7,742
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	0	0

COORDINATED CARE CORPORATION

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		57,097,421	
(2)	Company Action Level = 200% of Authorized Control Level	CAL	35,961,746	
(3)	Regulatory Action Level = 150% of Authorized Control Level	RAL	26,971,310	
(4)	Authorized Control Level = 100% of Authorized Control Level	ACL	17,980,873	
(5)	Mandatory Control Level = 70% of Authorized Control Level	MCL	12,586,611	
(6)	Level of Action, if Any	NONE		

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	57,097,421
Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page	17,980,873

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	569,967,437	
(8)	Underwriting Deductions	Page 4, Line 23	561,641,756	
(9)	Combined Ratio	Line (8)/Line (7)	98.539	
(10)	RBC Ratio	Line (1)/Line (4)	317.545	
(11)	Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then “Yes”, otherwise “No”		NO
(12)	Level of Action, if any, including Trend Test		NONE	

Appendix J
Coordinated Care Corporation
Data and Assumption Reliance for 2015 Individual Exchange Premium Development

Data / Assumption	Source
2015 Individual Exchange Enrollment	Charles Kearns, Centene
2015 Individual Exchange Market Share, by county and income bracket	Charles Kearns, Centene
2015 Individual Exchange Attrition, Market Share, and Buy-Ups (by FPL) Assumptions	Charles Kearns, Centene
Aggregate health insurance coverage transition rates, 2011-2014	SOA/Optum ("Cost of the Future Newly Insured under the Affordable Care Act (ACA)")
Pricing and Premium Development Models	Milliman
Basic tables of utilization, cost, claims probability distributions, pricing adjustment factors, and primary care/specialty care utilization distribution	Milliman (Health Cost Guidelines)
Pre-ACA Large Group Claims Cost PMPM	CCIIO (2011 MLR)
Pre-ACA Large Group Actuarial Value	MarketScan (Commercial Claims Database)
Pre-ACA Large Group Unit Costs	MarketScan (Commercial Claims Database) and Billed Charge Discounts (CMS Medicare claims data)
Prospective Morbidity Factors by Health Status, Age, and Gender	US Census Bureau (2009-2011 Current Population Survey), Milliman (Small Group Medical Underwriting Guidelines)
Health insurance transition rate relativities by age, gender, income, and health status	Milliman
Pre-ACA health status distribution by age, income, and insurance coverage	US Census Bureau (2009-2011 Current Population Survey)
Pre-ACA enrollment counts for Individual, Small Group Fully Insured, and Large Group Fully Insured markets	CCIIO (2011 MLR Dataset)
Pre-ACA enrollment counts for Employer Group, Part-Time, Retiree, Medicaid/Other Public, Medicare/Dual, and Uninsured markets	US Census Bureau (2011 American Community Survey)
Distribution of pre-ACA enrollment by age, gender, and income bracket, within each insurance coverage category	US Census Bureau (2011 American Community Survey)
State and Federal High Risk Pool Enrollment	National Conference of State Legislatures ("High Risk Pools for Health Coverage, State and Federal (State Implementation Report)")
2015 Individual Exchange Benefit Designs	Charles Kearns, Centene
Centene pre-ACA enrollment, claims data, and benefit designs	Charles Kearns, Centene
Utilization trends	Milliman
Unit Cost trends	Charles Kearns, Centene
Anticipated Centene Individual Exchange Unit Costs	Centene Reimbursement Targets based on Medicare (CMS Medicare claims data) and Billed Charge Discounts (CMS Medicare claims data)
Administrative Costs, Taxes, and Fees	Charles Kearns, Centene
CCHP Delinquency Numbers	Charles Kearns, Centene
Subcapitated Contracts and Pricing	Charles Kearns, Centene
Value Added Benefits	Charles Kearns, Centene
Smoking Relativity Factors	Charles Kearns, Centene/Milliman
County Rating Areas	Charles Kearns, Centene
Centene Service Areas	Charles Kearns, Centene
Expected Reimbursement by Rating Area and State	Charles Kearns, Centene
OON Inpatient Services Utilization	Charles Kearns, Centene
Utilization Management	Charles Kearns, Centene
3:1 Age Band Factors	HHS
Prescription Drug Assumptions: AWP Discount, Dispensing Fee, Rebates, Retail/Mail Utilization percentages, formularies, and Rx Management Assumptions	US Scripts
Capital, Surplus, and RBC from Annual Statement	Charles Kearns, Centene

Appendix K
Coordinated Care Corporation
Projected Experience with and without Requested Rate Change

	With Requested Rate Change	Without Requested Rate Change
Enrollment Projection	147,869	147,869
Earned Premium		
Next 12 Months	$430.88	$445.05
Next Full Calendar Year	$430.88	$445.05
Anticipated Implementation Date (1)	$430.88	$445.05
Projected Incurred Claims		
Next 12 Months	$320.76	$320.76
Next Full Calendar Year	$320.76	$320.76
Anticipated Loss Ratio		
Next 12 Months	74.4%	72.1%
Next Full Calendar Year	74.4%	72.1%

(1) Anticipated implementation date is 1/1/2015.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year*	0% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 2 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular

program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined	$75 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Preferred and Specialty	Deductible	
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered

• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the

requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental- Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	20% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	20% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	20% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined	$75 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Preferred and Specialty	Deductible	
Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	20% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered

Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	20% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	20% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered

• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the

requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit*	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$100 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,500 Individual $5,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$200 Individual $400 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $200 Prescription Drug Deductible combined with Non-Preferred and Specialty	$25 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $200 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $200 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 3 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$50 Individual $100 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$2 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $50 Prescription Drug Deductible combined with Non-Preferred and Specialty	$5 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $50 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $50 Prescription Drug Deductible combined with Non-Preferred and Preferred • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$2 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$2 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250
The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	20% Coinsurance after Deductible	Not Covered

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$30,000 for donor research		
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

 *Requires prior authorization – please contact the number listed on your ID card

Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

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Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$2,000 Individual $4,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 transportation and lodging $30,000 for donor research	20% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	20% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$40 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	20% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	20% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$15 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	$100 Copayment	Not Covered
Specialty*	20% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	20% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	20% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	20% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	20% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	20% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	20% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	20% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	20% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	20% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	20% Coinsurance after Deductible	Not Covered
Hospice Services*	20% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	20% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	20% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$40 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	20% Coinsurance after Deductible	Not Covered

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$30,000 for donor research		
Diabetes Care Management*	$40 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

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Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	10% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	$75 Copayment	Not Covered
Specialty*	10% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered

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Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor research		
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

 *Requires prior authorization – please contact the number listed on your ID card

Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 4 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$100 Individual $200 Family	N/A
Coinsurance For All Other Eligible Expenses	5% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	5% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	5% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$5 Copayment	Not Covered
Non-Preferred Brand*	$25 Copayment	Not Covered
Specialty*	5% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	5% Coinsurance after Deductible	Not Covered

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Outpatient Surgery Physician/Surgical Services *	5% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	5% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$50 Copayment after Deductible	$50 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	5% Coinsurance after Deductible	5% Copayment after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	5% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	5% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	5% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	5% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	5% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	5% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	5% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	5% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	5% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	5% Coinsurance after Deductible	Not Covered
Hospice Services*	5% Coinsurance after Deductible	Not Covered
Private Nursing Duty* 82 visits per year	5% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	5% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	5% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered

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Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered

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Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

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• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$1,000 Individual $2,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$50 Copayment	Not Covered
Specialist Physician Office Visit	$75 Copayment	Not Covered
Other Practitioner Office Visit	$50 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$75 Copayment after Prescription Drug Deductible	Not Covered

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Specialty* • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$250 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$50 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	$250 Copayment after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$250 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$50 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$75 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$75 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$3,000 Individual $6,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$20 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$20 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$50 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$150 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $500 Prescription Drug Deductible combined with Preferred and Specialty	$50 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $500 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$150 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$25 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$1,000 Copayment per day after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$150 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$150 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$1,000 Copayment per day after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$20 Copayment	Not Covered
Delivery and Inpatient Services *	$1,000 Copayment per day after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$50 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$1,000 Copayment per day after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$50 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$100 Copayment after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$1,000 Copayment per day after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$100 Individual $200 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$10 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$50 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand • $1,000 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $1,000 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

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Specialty • $1,000 Prescription Drug Deductible combined with Non-Preferred and Preferred	$250 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$10 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$250 Copayment after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$250 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$250 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	$250 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$250 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$200 Copayment per Stay	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$250 Copayment after Deductible	Not Covered
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 5 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$5 Copayment	Not Covered
Specialist Physician Office Visit	$10 Copayment	Not Covered
Other Practitioner Office Visit	$5 Copayment	Not Covered
Preventive Care (including screenings, well baby visit and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	$0 Copayment after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	$25 Copayment after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$20 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand • $0 Prescription Drug Deductible combined with Preferred and Specialty	$40 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	$100 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	$50 Copayment after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	$0 Copayment after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$100 Copayment after Deductible	$100 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$100 Copayment per Stay after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$50 Copayment after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	$100 Copayment after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$50 Copayment after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	$100 Copayment after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$5 Copayment	Not Covered
Delivery and Inpatient Services *	$100 Copayment after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	$0 Copayment after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	$10 Copayment after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	$100 Copayment after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	$10 Copayment after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	$0 Copayment after Deductible	Not Covered
Durable Medical Equipment *	$0 Copayment after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Hospice Services*	$0 Copayment after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	$0 Copayment after Deductible	Not Covered
Accidental Dental $3,000 per year	$0 Copayment after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$10 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	$100 Copayment after Deductible	Not Covered
Diabetes Care Management*	$10 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$60 Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		

Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance	0% Coinsurance
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance
Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		

 *Requires prior authorization – please contact the number listed on your ID card

Inpatient Hospital Facility*	0% Coinsurance	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months		

• Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,000 Individual $10,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$30 Copayment	Not Covered
Specialist Physician Office Visit	$60 Copayment	Not Covered
Other Practitioner Office Visit	$30 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$30 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$30 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$30 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$60 Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$60 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		

*Requires prior authorization – please contact the number listed on your ID card

Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 2 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$4,000 Individual $8,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$20 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand*	$50 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$10 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$20 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$10,000 for transportation and lodging $30,000 for donor search	Deductible	
Diabetes Care Management*	$20 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		

*Requires prior authorization – please contact the number listed on your ID card

Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	Ambetter Balanced Care 2 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,500 Individual $3,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$1,500 Individual $3,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

$30,000 for donor search		
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to	Not Covered

Routine Cleaning – 1 per 6 months	Annual Maximum	
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	Ambetter Balanced Care 2 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$500 Individual $1,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand*	$25 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered

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Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		

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Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined with Non-Preferred and Preferred	50% Coinsurance after Prescription Drug Deductible	Not Covered

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Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered

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Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other	$1,000 per covered person per calendar year	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

maximums)		
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, wells baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand*	$0 Copayment	Not Covered
Non-Preferred Brand*	0% Coinsurance	Not Covered
Specialty*	0% Coinsurance	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance	0% Coinsurance

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Urgent Care	$0 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$0 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services*	$0 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance	Not Covered
Durable Medical Equipment *	0% Coinsurance	Not Covered
Hospice Services*	0% Coinsurance	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit*	0% Coinsurance	Not Covered
Diabetes Care Management*	$0 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent		

Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Prescription Drug Deductible per Calendar Year	$750 Individual $1,500 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$25 Copayment	Not Covered
Specialist Physician Office Visit	$50 Copayment	Not Covered
Other Practitioner Office Visit	$25 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$10 Copayment	Not Covered
Preferred Brand* • $750 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $750 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $750 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$100 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$25 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$25 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$25 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 100 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$50 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$50 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		

Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - 73% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$1,750 Individual $3,500 Family	N/A
Prescription Drug Deductible per Calendar Year	$500 Individual $1,000 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$5,200 Individual $10,400 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$10 Copayment	Not Covered
Specialist Physician Office Visit	$30 Copayment	Not Covered
Other Practitioner Office Visit	$10 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$5 Copayment	Not Covered
Preferred Brand* • $500 Prescription Drug Deductible combined with Non-Preferred and Specialty	$60 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $500 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $500 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$400 Copayment after Deductible	$400 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$75 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$10 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$10 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care (including well baby visits)	$10 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$30 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$30 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		

*Requires prior authorization – please contact the number listed on your ID card

Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - 87% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	N/A
Prescription Drug Deductible per Calendar Year	$150 Individual $300 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$2,250 Individual $4,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	30% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	30% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $150 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $150 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $150 Prescription Drug Deductible combined	50% Coinsurance after Prescription Drug	Not Covered

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with Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	30% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	30% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$250 Copayment after Deductible	$250 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	30% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	30% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	30% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	30% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 visits per year	30% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 days per year	30% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	30% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	30% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	30% Coinsurance after Deductible	Not Covered
Hospice Services*	30% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	30% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	30% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	30% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		

 *Requires prior authorization – please contact the number listed on your ID card

Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Balanced Care 1 + Vision + Adult Dental - 94% AV Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	30% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$750 Individual $1,500 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$1 Copayment	Not Covered
Specialist Physician Office Visit	$5 Copayment	Not Covered
Other Practitioner Office Visit	$1 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	10% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	10% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$1 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$30 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	50% Coinsurance after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with	50% Coinsurance after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Non-Preferred and Preferred	Deductible	
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	10% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$150 Copayment after Deductible	$150 Copayment after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$50 Copayment	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	10% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$1 Copayment	Not Covered
Mental/Behavioral Health Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	$1 Copayment	Not Covered
Substance Abuse Disorder Inpatient Services*	10% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$1 Copayment	Not Covered
Delivery and Inpatient Services *	10% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy) 60 days per year	10% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	10% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	10% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	10% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	10% Coinsurance after Deductible	Not Covered
Hospice Services*	10% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	10% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	10% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$5 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	10% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	$5 Copayment	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		

 *Requires prior authorization – please contact the number listed on your ID card

Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

	Deductible	
Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility*	40% Coinsurance after	Not Covered

90 days per year	Deductible	
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit*	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	$0 Copayment	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,000 Individual $12,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit*	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	40% Coinsurance after Deductible	Not Covered

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 60 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	40% Coinsurance after Deductible	Not Covered

Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Not Covered
Lenses (per pair)		
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• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	100% Covered after Copayment	Not Covered
Vision Services – Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
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• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered

Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational, Physical Therapy and Pulmonary Rehab)* 20 visits per benefit per year Cardiac Rehabilitation - separate 36 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered

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Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor research	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered

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• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (dental out of pocket maximum does not apply toward any other maximums)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$4,000 Individual $8,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,350 Individual $12,700 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit • 3 free visits per person, 4th visit and after are subject to Deductible and Coinsurance	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$100 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$150 Copayment after Deductible	Not Covered

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Specialty* • Covered at 100% after $350 eligible coinsurance charges applied	30% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
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Copayment for Exams and Eyewear	$20 Copayment	Not Covered
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Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
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Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		

*Requires prior authorization – please contact the number listed on your ID card

Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* • 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered
• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered

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Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

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Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 days per year	0% Coinsurance after Deductible	Not Covered

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Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

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• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 2 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$5,000 Individual $10,000 Family	N/A
Coinsurance For All Other Eligible Expenses	40% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	40% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	40% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	40% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	40% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$25 Copayment	Not Covered
Preferred Brand*	$50 Copayment after Deductible	Not Covered
Non-Preferred Brand*	$100 Copayment after Deductible	Not Covered
Specialty*	40% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	40% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	40% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	40% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	40% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	40% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	40% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	40% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	40% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	40% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	40% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	40% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	40% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	40% Coinsurance after Deductible	Not Covered
Hospice Services*	40% Coinsurance after Deductible	Not Covered

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Private Duty Nursing* 82 visits per year	40% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	40% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	40% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	40% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	40% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
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• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
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• Contact Lens Fitting	100% Covered after Copayment	Not Covered

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• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
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[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered

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Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
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Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
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Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental - Zero Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$0 Individual $0 Family	N/A
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$0 Individual $0 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	$0 Copayment	Not Covered
Specialist Physician Office Visit	$0 Copayment	Not Covered
Other Practitioner Office Visit	$0 Copayment	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$0 Copayment	Not Covered
Preferred Brand* • $0 Prescription Drug Deductible combined with Non-Preferred and Specialty	$0 Copayment after Prescription Drug Deductible	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with	$0 Copayment after Prescription Drug	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Preferred and Specialty	Deductible	
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred and Preferred	0% Coinsurance after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	$0 Copayment	Not Covered
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0 Copayment	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility 90 days per year	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered
Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available

for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

[Plan Information]

[Health Plan:]	[Ambetter Essential Care 1 + Vision + Adult Dental - Limited Cost Sharing]
[Primary Member:]	[John Doe]
[Member ID:]	[01213456]
[Date of Birth:]	[08/12/62]
[Effective Date:]	[01/01/15]
[Last Coverage Change Date:]	[01/01/15]

[Dependent Information]

[First Name:]	[Jane Doe]
[Relationship to You:]	[Spouse]
[Birth Date:]	[08/12/62]
[Effective Date:]	[01/01/15]

Benefit	Insured Responsibility(per person)	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$6,500 Individual $13,000 Family	N/A
Coinsurance For All Other Eligible Expenses	0% Coinsurance after Deductible	N/A
Out-Of-Pocket Maximum per Calendar Year	$6,500 Individual $13,000 Family	N/A
Physician Office Services		
Primary Care Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Specialist Physician Office Visit	0% Coinsurance after Deductible	Not Covered
Other Practitioner Office Visit	0% Coinsurance after Deductible	Not Covered
Preventive Care (including screenings, well baby visits and immunizations)	$0 Copayment	Not Covered
Diagnostic Test (x-ray and lab-work)*	0% Coinsurance after Deductible	Not Covered
Imaging Test (CT/PET scans, MRI)*	0% Coinsurance after Deductible	Not Covered
Prescription Drugs		
Generic	$20 Copayment	Not Covered
Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Non-Preferred Brand*	0% Coinsurance after Deductible	Not Covered
Specialty*	0% Coinsurance after Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

	Sharing	
Outpatient Services		
Outpatient Facility*	0% Coinsurance after Deductible	Not Covered
Outpatient Surgery Physician/Surgical Services *	0% Coinsurance after Deductible	Not Covered
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	Not Covered
Emergency and Urgent Care Services		
Emergency Room	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after deductible
Urgent Care	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Services*		
Inpatient Hospital Facility*	0% Coinsurance after Deductible	Not Covered
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	Not Covered
Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Mental/Behavioral Health Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Outpatient Services*	0% Coinsurance after Deductible	Not Covered
Substance Abuse Disorder Inpatient Services*	0% Coinsurance after Deductible	Not Covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	0% Coinsurance after Deductible	Not Covered
Delivery and Inpatient Services *	0% Coinsurance after Deductible	Not Covered
Other Covered Services		
Home Health Care Services* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy)* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Rehabilitation Inpatient Services (Including Speech, Occupational and Physical Therapy)* 60 days per year	0% Coinsurance after Deductible	Not Covered
Cardiac Rehabilitation 36 visits per year	0% Coinsurance after Deductible	Not Covered
Habilitation Services* 20 visits per benefit per year	0% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility* 90 visits per year	0% Coinsurance after Deductible	Not Covered
Durable Medical Equipment *	0% Coinsurance after Deductible	Not Covered
Hospice Services*	0% Coinsurance after Deductible	Not Covered

 *Requires prior authorization – please contact the number listed on your ID card

Private Duty Nursing* 82 visits per year	0% Coinsurance after Deductible	Not Covered
Accidental Dental $3,000 per year	0% Coinsurance after Deductible	Not Covered
Chiropractic Care* 12 visits per year	0% Coinsurance after Deductible	Not Covered
Transplant Benefit* $10,000 for transportation and lodging $30,000 for donor search	0% Coinsurance after Deductible	Not Covered
Diabetes Care Management*	0% Coinsurance after Deductible	Not Covered
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams and Eyewear	$0 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered	Not Covered
Eyeglasses (frames) and contacts 1 item per year	100% Covered	Not Covered
Lenses (per pair)		
• Single	100% Covered	Not Covered
• Bifocal	100% Covered	Not Covered
• Trifocal	100% Covered	Not Covered
• Lenticular	100% Covered	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered	Not Covered
• Contact Lens Fitting	100% Covered	Not Covered
• Specialty Lens Fitting	100% Covered	Not Covered
Vision Services –Adult (Ages 19 years of age and older)		
Copayment for Exams and Eyewear	$20 Copayment	Not Covered
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Not Covered
Eyeglasses (frames) and contacts 1 item per year	Covered up to $130 after Copayment	Not Covered
Lenses (per pair)		
• Single	100% Covered after Copayment	Not Covered
• Bifocal	100% Covered after Copayment	Not Covered
• Trifocal	100% Covered after Copayment	Not Covered
• Lenticular	100% Covered after Copayment	Not Covered
Contact Lenses		
• Contact lenses (in lieu of glasses)	Covered up to $130 after Copayment	Not Covered
• Contact Lens Fitting	100% Covered after Copayment	Not Covered

*Requires prior authorization – please contact the number listed on your ID card

• Specialty Lens Fitting	Covered up to $50 after Copayment	Not Covered
Dental – Adult (Ages 19 years of age and older)		
Annual Maximum (Dental out of pocket maximum does not apply toward any other maximums.)	$1,000 per covered person per calendar year	Not Covered
Basic Dental (Class 1)		
Routine Oral Exam – 1 per 6 months	No charge, subject to Annual Maximum	Not Covered
Routine Cleaning – 1 per 6 months		
Bite-wing X-ray – 1 per 12 months		
Full Mouth X-ray – 1 per 60 months		
Panoramic Film – 1 per 60 months		
Topical Fluoride Application – 2 per 12 months		
Palliative Treatment for Relief of Pain (minor procedures)		
Comprehensive Dental (Class 2)		
Basic Services • Silver Fillings – 1 per 2 years • Tooth Colored Fillings – 1 per 2 year, front teeth only	50% coinsurance, subject to Annual Maximum	Not Covered
Endodontics • Therapeutic Pulpotomy on permanent Teeth – 1 per lifetime per tooth		
Periodontics • Scaling and Root Planning – 1 per 24 months • Periodontal Maintenance – 4 in 12 months		
Oral Surgery • Simple Extractions • Surgical Extractions • Removal of Impacted Teeth • Alveoloplasty		
Prosthodontics • Relines – 1 per 36 months • Rebase – 1 per 36 months • Adjustments • Repairs		

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.bchpohio.com/ or by contacting Member Services by telephone at 1-877-687-1189.

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and refuse to renew all polices 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.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at http://ambetter.mhsindiana.com/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter from MHS Network. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed 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.*

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Contract when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

The *deductible amount* does not include any copayment amounts.

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* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

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 *generally accepted 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.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services.
2. Determination to reform or rescind a policy.
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-Network Provider means a *medical practitioner* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Post-service claim means any claim for 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.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered 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 expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Prosthetic device means an artificial leg or arm.

Provider facility means a *hospital, rehabilitation facility*, or *extended care facility*.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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 Indiana to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members
A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract, we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
18. 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.

19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits
Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits
Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. 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 that 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.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her Medical Practitioner.

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits
Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a

Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage
Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person*

is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits

Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage

contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and refuse to renew all polices 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.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at http://ambetter.mhsindiana.com/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter from MHS Network. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed 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.*

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Contract when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

The *deductible amount* does not include any copayment amounts.

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* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

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 *generally accepted 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.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services.
2. Determination to reform or rescind a policy.
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-Network Provider means a *medical practitioner* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Post-service claim means any claim for 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.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered 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 expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Prosthetic device means an artificial leg or arm.

Provider facility means a *hospital, rehabilitation facility*, or *extended care facility*.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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 Indiana to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members
A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract, we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
18. 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.

19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits
Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits
Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. 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 that 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.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her Medical Practitioner.

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits
Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through OptiCare. 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, contact OptiCare 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 OptiCare'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. If you elect contact lenses in lieu of glasses, 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 OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision Adult 19 years of age and older and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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
- Out of network care, except for pre-authorized.

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, Basic (Class 1) and Comprehensive (Class 2) dental services from an *In-Network provider*. *Covered services* for restorative care are subject to a 6 month

waiting period. Please refer to your Schedule of Benefits for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which dental providers are part of the network, please call Member Services or visit http://ambetter.mhsindiana.com/.

1. Basic (Class 1) benefits include:
   a. Routine Oral Exams;
   b. Routine Cleanings;
   c. Bite-wing X-rays;
   d. Full-Mouth X-Rays;
   e. Panoramic Film;
   f. Topical fluoride application; and
   g. Palliative Treatment for Relief of Pain (minor procedures).
2. Comprehensive (Class 2) benefits include:
   a. Basic Services – including silver filings and tooth colored filings;
   b. Endodontics – including therapeutic pulpotomy;
   c. Periodontics – including scaling, root planning and periodontal maintenance;
   d. Oral Surgery – including simple extractions, surgical extractions, removal of impacted tooth and alveoloplasty; and
   e. Prosthodontics – including relines, rebase, adjustment and repairs.

Services not covered for adult Basic (Class 1) and Comprehensive (Class 2) benefits include:

1. Out of network services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. Prescription drugs;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the member's *effective date* of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant procedures;
11. Surgical replacements;
12. Sinus augmentation;
13. Surgical appliance removal;
14. Intraoral placement of a fixation device;
15. Oral hygiene instruction, tobacco counseling, nutritional counseling;
16. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
17. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
18. Root canal therapy;
19. Analgesia (nitrous oxide);
20. Removable unilateral dentures;

21. Temporary procedures;
22. Splinting;
23. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
24. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
25. Consultations by the treating provider and office visits;
26. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's *effective date*;
27. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
28. Veneers (bonding of coverings to the teeth);
29. Orthodontic treatment procedures;
30. Corrections to congenital conditions, other than for congenital missing teeth;
31. Athletic mouth guards;
32. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment; and
33. Space maintainers for anyone 19 years of age or older.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage

Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage
Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:

a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage

contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. We will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.
The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Ambetter Individual Health Benefit Plan
Issued and Underwritten by Coordinated Care Corporation, dba MHS

Home Office: 1099 North Meridian Street, Suite 400 Indianapolis, IN 46204
Individual Member Contract

In this *contract, "you"*, *"your", "yours" or "member"* will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and *"we," "our,"* or *"us"* will refer to Coordinated Care Corporation.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is incorporated into the *contract*. *We* will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *we* may 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.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and refuse to renew all polices 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.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

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*.

MHS

Patrick Rooney
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from MHS! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us
Ambetter from MHS
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-877-941-9232**
Fax **1-877-941-8072**
Emergency **911**
NurseWise **1-877-687-1182 (24 hour nurse advice line)**

Interpreter Services
Ambetter from MHS has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1182 (TDD/TTY 1-877-941-9232).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

14. A current list of *network providers*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
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 physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
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 physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Services department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at http://ambetter.mhsindiana.com/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter from MHS Network. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1182. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1182. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to 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 http://ambetter.mhsindiana.com/. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. Member Rights and Responsibilities.
7. Notice of Privacy Practices.
8. Current events and news.

If *you* have material modifications or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, 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 physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical 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*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. 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 a 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:
Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; *copayment amounts*; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
    a. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
    b. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
    c. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed 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.*

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*.

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, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Contract when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage.*

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 percentage means the percentage of *covered services* that are payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses* , shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount.* For family coverage, the *family deductible* amount can be met with the combination of any one or more *covered persons'* eligible expenses.

The *deductible amount* does not include any copayment amounts.

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* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange 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* as determined below.

1. For *network providers* (excluding Transplant Benefits): 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;* or
    b. As otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts; or
    c. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine meets the definition of Emergency Care will be covered by any Provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. You must notify Us or verify that your Physician has notified Us of your admission to a hospital within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By contacting *us*, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not contract with *us* you will be financially responsible for any care *we* determine is not Medically Necessary. Care and treatment provided once you are Medically Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, , maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this *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.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

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 *generally accepted 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.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services.
2. Determination to reform or rescind a policy.
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 *generally accepted 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.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
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; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 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.
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.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount 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, Coordinated Care pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* 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. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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 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 an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible 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 means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-Network Provider means a *medical practitioner* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

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.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pervasive Developmental Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Post-service claim means any claim for 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.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered 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 expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Prosthetic device means an artificial leg or arm.

Provider facility means a *hospital, rehabilitation facility*, or *extended care facility*.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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 Indiana to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

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 abuse means alcohol, drug or chemical abuse, overuse, or dependency.

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.

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.

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 date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for 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. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's 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 not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. 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 by the Marketplace of the child's birth.

Coverage for 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 on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members
A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
3. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan.

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.* For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.
All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. At the *dependent members* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 28 if the *dependent member*:

- Is the natural child, stepchild or adopted child of the *member*.
- Is a resident of Ohio or a full-time student at an accredited higher education institution.
- Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage.
- Is not eligible for coverage under Medicaid or Medicare.

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. Chiefly dependent on *the Primary Member* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015, will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
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. 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;
5. 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;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the 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;
7. A *Qualified individual* or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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
10. 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. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 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.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract, we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

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*.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount*(*s*) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be 100%.

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* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician
In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* 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 physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Changing The Deductible
You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

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.*

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. 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.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use

disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, 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, including *pervasive developmental disorders*. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse 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, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis Stabilization; and
5. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP)
2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Biofeedback; and
4. Psychological Testing.

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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Non-Covered Services:
(Physical Therapy) 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. (Occupational Therapy) Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: 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. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.

b. Infusion pump or cassette.
c. Portable commode.
d. Patient lift.
e. Bili-lights.
f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling, refer to your Schedule of Benefits*.

Miscellaneous Major Medical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room.
    d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner.*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *g percentage* provisions.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
18. 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.

19. 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.
20. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
21. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
22. Allergy testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits
Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including medically necessary repairs or replacement to restore or maintain a member's ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. For *medically necessary* biofeedback services.
12. For *medically necessary* allergy treatment.

Outpatient Prescription Drug Expense Benefits
Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. 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 that 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.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her Medical Practitioner.

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.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
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. Due to a *member's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription, except when the drug is prescribed for preventive care.
13. 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.
14. Off-label use, except as otherwise prohibited by law or as approved by *us*.

Pediatric Vision Expense Benefits
Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of medically necessary contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Non-Network Providers

Other Dental Services
Anesthesia and Hospital charges for dental care, for a *Member* less than 19 years of age or a *Member* who is physically or mentally disabled, are covered if the *Member* requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Dental Anesthesia Coverage
Covered service expenses in an outpatient or *hospital* setting for dental care as the result of an accidental *injury* when the treatment is performed within 12 months.

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 breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
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 health care 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.*

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a female *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for any male *covered person* who is at least fifty (50) years of age; and at least once annually for a male *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 earlier than one year after the recommendation or guideline is issued.

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.

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 health care 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.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- 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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *listed 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.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the Schedule of Benefits for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*

9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits
Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. *You* may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.mhsindiana.com/ or by contacting Member Services by telephone at 1-877-687-1182. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

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.*

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the Contract.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. 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.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
16. For diagnosis or treatment of learning disabilities
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
22. 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.
23. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
24. For hearing aids, except as expressly provided in this *contract*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm.
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *member* taking part in a riot.
    d. The *member's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.
34. 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.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports);

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. 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.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service ; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
40. For court ordered testing or care unless Medically Necessary;
41. 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;
42. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Residential programs for drug and alcohol.

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

TERMINATION

Termination of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.

Paid premiums that are not earned due to *contract* termination will be refunded.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage

contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

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.

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

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 for the *member's loss*. *We* will have the right to be reimbursed to the extent 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*.

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* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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 have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.

2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for

example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual

knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

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
You or *your* covered *dependent member* must give *us* 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 in that year.*

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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/grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that *complaint/grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your complaint/grievance*.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the policy, also described as the claimant;
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format.
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Grievances

A Grievance is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or medically necessary,
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this contract,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the policy.

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. You can also write a letter and mail or fax your Grievance to MHS at 1-866-714-7993. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Claimants have the right to submit a grievance in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A grievance may be filed by calling our toll-free member services number at 1-877-687-1182. Members may request assistance in filing a grievance with our health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of a grievance.

Process and Resolution Timeframes

1. We will offer an acknowledgement of the grievance within 3 (three) business days of initial receipt of the grievance, either orally or in written form, to the covered individual. When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.
    (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
    (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
    (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.
2. Grievances regarding quality of care, quality of service, or reformation will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if we provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
3. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the grievance decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A member or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Coordinated Care under the Contract and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 866-714-7993 or mailed to Ambetter from MHS at:

Grievance and Appeals Coordinator
1099 North Meridian Street
Suite 400
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. You may request a copy of this summary to be mailed to you. An acknowledgement letter, of the appeal, will be sent within three (3) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to

continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you written acknowledgement letter within three (3) business day of receipt of your appeal. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If you are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Coordinated Care will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Coordinated Care and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. You have the right to appear in person to person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre service non-expedited Internal Appeal no later than 45 days from notification from the claimant of the appeal. We will notify you of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, your appeal will be assigned to one or more individuals to handle the process of your appeal. The committee will include individuals that:

- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);
- Are not involved or have not been involved in the matter which created the appeal &/or were not involved in the initial grievance investigation of the matter; and,
- Do not have a direct business or personal relationship with the member or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION
We will provide a written notification to you within 5 business days after completion of the investigation and not later than 30 days from initial receipt of the appeal. The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about your appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The member's right to obtain an independent External Review through the IRO including the timeframe for filing.

- Contact information, including address and telephone number, to obtain additional information on the appeal &/or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

EXPEDITED INTERNAL APPEAL
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a provider may act as your authorized representative without a signed written consent from you.

If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Ambetter from MHS.

External Review
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review G*rievance & Appeals procedures* apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

The claimant has 120 days to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response the grievance or appeal.

1. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a

disability that the decision would seriously jeopardize the individual's health, life, or ability to reach &/or maintain maximum function.

External review is available for *grievances and appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

We have fifteen business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the member should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. However, the IRO has only 24 hours to notify the insured and the health plan after reaching a decision; and, a decision must be reached within 72 hours from receipt of the expedited external review request.

Member Rights & Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other covered benefits associated with your health insurance policy. You may also submit any new or additional information as a part of the external review process for further consideration of your grievance or appeal. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the grievance, appeal, or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your policy or coverage should be directed to:

COORDINATED CARE CORPORATION dba MHS
Home Office: 1099 North Meridian Street, Suite 400
Indianapolis, IN 46204
1-877-687-1182

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Actuarial Memorandum

Coordinated Care Corporation

Individual Health Rate Filing

Effective January 1, 2015

Forms: 35065IN001, 35065IN002, 35065IN003

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1. General Information

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Coordinated Care Corporation's Individual health block of business, effective January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT) and the Part II Written Justification.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This actuarial memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene, parent company of Coordinated Care Corporation, and Milliman, Inc. dated January 13, 2003. This information is intended for use by the Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Coordinated Care Corporation's Individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for Coordinated Care Corporation by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions. This is a renewal rate filing. The purpose of this filing is to meet the requirements of the State of Indiana statutes and demonstrate that the benefits are reasonable in relation to the premium charged.

Company Identifying Information:

- Company Legal Name: Coordinated Care Corporation
- State: The State of Indiana has regulatory authority over these policies.
- HIOS Issuer ID: 35065
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information:

- Primary Contact Name: Jon Szerszen
- Primary Contact Telephone Number: (312) 332-8560
- Primary Contact Email Address: jszerszen@celtic-net.com

Description of Benefits:

These products are HMO health policies issued by Coordinated Care Corporation. Each plan below can be a stand-alone plan, have adult vision coverage, or have both adult vision and adult dental coverage. The major provisions of this form for each plan design and product are as follows:

Plan Design	Med Deductible	Plan Coins	Rx Deductible	OOP Max	PCP Visit	Spec Visit	Rx Copay
Ambetter Secure Care 2	$500	80%	$500	$6350	$50 NSD	$75 NSD	$15 NSD/$30 SD/$100 SD/30% SD / Max $350
Ambetter Secure Care 1 with 3 Free PCP Visits	$1000	80%	$500	$6350	D&C	D&C	$10 NSD/$25 SD/$75 SD/30% SD / Max $350
Ambetter Balanced Care 3	$2500	70%	$1000	$6350	$50 NSD	$75 NSD	$20 NSD/$50 SD/$100 SD/D&C / Max $350
Ambetter Balanced Care 4	$2000 INT	80%	INT	$6350	$50 NSD	$75 NSD	$20 NSD/$50 NSD/$100 SD/D&C
Ambetter Balanced Care 5	$3000	100%	$1000	$6350	$50 NSD	$75 NSD	$10 NSD/$50 SD/$75 SD/$250 SD
Ambetter Balanced Care 1	$5000	70%	$750	$6350	$25 NSD	$50 NSD	$10 NSD/$60 SD/50% SD/50% SD
Ambetter Balanced Care 2	$5000 INT	100%	INT	$5000	$30 NSD	$60 NSD	$10 NSD/$50 NSD/D&C/D&C
Ambetter Essential Care 2	$5000 INT	60%	INT	$6500	D&C	D&C	$25 NSD/$50 SD/$100 SD/D&C

Ambetter Essential Care 1	$6500 INT	100%	INT	$6500	D&C	D&C	$20 NSD/D&C/D&C /D&C
Ambetter Essential Care 3 with 3 Free PCP Visits	$6000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$50 SD/$100 SD/30% SD / Max $350
Ambetter Essential Care 4 with 3 Free PCP Visits	$4000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$100 SD/$150 SD/30% SD / Max $350

D&C – Deductible and Coinsurance

INT – Integrated Medical and Rx Deductible

NSD – Not subject to deductible

SD – Subject to deductible

Rx Copay – Generic / Preferred Brand / Non-Preferred Brand / Specialty

Rate Guarantees:

Rates are guaranteed not to change through December 31, 2015.

Renewability:

Each policy is renewable by paying the applicable renewal premiums unless the policy holder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability:

The rates will apply to new and renewing business.

General Marketing Method:

This product will be sold through agents, direct mailings, the internet, and the Federally Facilitated Exchange.

Estimated Average Annual Premium:

The following is a comparison of estimated average annual premium per policy:

Date	Nationwide*	Indiana
Calendar Year 2015	$5,171	$5,171

*Note that the products to which this rate filing applies are offered only in Indiana.

Distribution of Business:

See Appendix A for the expected age and geographic distributions for these products.

Rate Tables:

See Appendix B for base rate and allowable rating factors. Appendix B also includes an example of how rating factors will be applied. Note that for family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Patient Protection and Affordable Care Act (ACA).

The geographic factors are developed based upon contractual reimbursement differences and expected utilization differences in each of the established rating areas. Based upon the expected distribution of enrollment by area, the geographic factors reflect the single risk pool results consistent with the URRT. The geographic factors for unit cost and utilization differences within the manual rate model vary by Metropolitan Service Area (MSA), and are a component to the geographic factor. To the extent the established rating area is a subset of an MSA, the manual rate model geographic factors are supplemented with county specific unit cost relativities.

The age band factors are prescribed through the ACA guidance.

The tobacco factors are developed based on Milliman research and are within the 1.0 to 1.5 tobacco factor range.

Premium Modalization:

Premiums will be collected only on a monthly basis.

Trend Assumption:

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2. Proposed Rate Increase(s)

The rate increases for each product offered by Coordinated Care Corporation in the State of Indiana are reflected in Worksheet 2, Section I of the Part I URRT.

Reasons for Rate Increase(s):

The rate projections for 2015 have been updated from the previous year's projections to reflect the most recent information available.

Here is a description of the significant factors driving the proposed rate increase for 2015:

- Change in Single Risk Pool Experience

  The morbidity for the Individual market population in 2015 was estimated using the Milliman State Impact Model (SIM). There is a full description of this model in the Credibility Manual Rate Description section.

- Unit Cost Trend

  Unit costs and reimbursement agreements with providers have changed between 2014 and 2015.

- Utilization Trend

  The utilization assumption is based on the Milliman Health Cost Guidelines. There is a full description of this model in the Credibility Manual Rate Description section.

- Prospective changes to benefits covered by the product or successor products

  The benefits covered are not expected to change during the effective period.

- New taxes and fees imposed on the issuer

  Premium rates have been adjusted to reflect the schedule of taxes and fees for 2015. While there were no new tax categories added between 2014 and 2015, the rates of the taxes changed. For the Health Insurance Provider Fee, the percentage was recalculated to reflect that the federal government plans on collecting $11.3 billion for 2015, compared to $8.0 billion for 2014. The Patient Centered Outcomes Research Fee has been increased from the 2014 amount.

- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

Assumptions for the Federal Transitional Reinsurance Program have been updated for 2015. Both the fee charged and the expected benefits will be reduced from 2014 to 2015. Here are the specific changes in parameters from 2014 (as of the time of pricing in May 2013) to 2015:

- Claims attachment point: Increasing from $60,000 to $70,000
- Reinsurance Cap: Remaining at $250,000
- Coinsurance Rate: Decreasing from 80% to 50%.
- Reinsurance Issuer Fee: Decreasing from $5.25 PMPM to $3.67 PMPM.

3. Experience Period Premium and Claims

Not applicable. At the time of this filing, data was not available.

4. Benefit Categories

The Milliman Health Cost Guidelines (HCG) were used to categorize the projected claims into the benefit categories in Worksheet 1, Section II. The detailed benefit categories from the HCGs were then consolidated into the categories shown on Worksheet 1, Section II of the Part I URRT. See Appendix C for a description of this mapping.

5. Projection Factors

Not applicable. This is a filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6. Credibility Manual Rate Development

Source and Appropriateness of Experience Data Used

Expected morbidity for the Indiana Individual market population in 2015 was estimated using the Milliman State Impact Model (SIM). The SIM is designed to model population shifts across insurance markets due to health reform and quantify the impact of these shifts on the composite morbidity for each market.

The SIM combines demographic data from the American Community Survey, the Current Population Survey, and cost data from CCIIO MLR reports in order to develop a comprehensive picture of Indiana's pre-ACA marketplace by insurance coverage (including uninsured), age, gender, income, and self-reported health status.

Morbidity factors based on two Milliman tools: the Health Cost Guidelines; and the Small Group Medical Underwriting Guidelines; are assigned to each member in the population. The morbidity factors vary based on the member's age, gender, and self-reported health status.

The impact of health reform on the Indiana insurance markets is modeled by transitioning enrollees across insurance coverage categories, assuming a static population. Modeled transitions include the following:

-Employer Plan Termination
-Voluntary Employee Termination and Early Retirement
-Uninsured Insurance Participation
-Disenrollment from the Individual Market as a Reaction to Post-ACA Community Rating
-Exchange Participation by Existing Off-Exchange Individual Insurance Enrollees
-State and Federal High Risk Pool Termination

Transition rates vary by insurance coverage, age, gender, income, and self-reported health status. Aggregate transition rates between insurance coverage pairs were initially calibrated based on aggregate transition rates from the March 2013 SOA/Optum Study "Cost of the Future Newly Insured under the Affordable Care Act (ACA)"[1], and subsequently adjusted based on implied individual Exchange enrollment rates through February 1, 2014 published in the February 12, 2014 ASPE Issue Brief "Health Insurance Marketplace: February Enrollment Report"[2].

Composite morbidity is then calculated for each pre-ACA and post-ACA insurance market based on the distribution of membership by age, gender, and self-reported health status. A Pent-Up Demand adjustment is applied to the morbidity of the newly insured (those who transitioned from uninsured to

[1] http://www.soa.org/NewlyInsured/

[2] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

insured), ranging from 2.5% for members reporting in Excellent or Very Good health to 5% for members in Good or Fair/Poor health.

The composite morbidity factors were then used to calibrate the Managed Care Rating Model (MCRM) to the projected Individual population for Indiana by scaling utilization in the model's basic tables to reflect the ratio of pre-ACA Large Group morbidity which is the MCRM base assumption to projected post-ACA Individual On-Exchange morbidity from the SIM.

The manual rate development is based on the calibrated MCRM and the companion HCGs. The MCRM includes several adjustments from the HCGs to adjust to be consistent with the expected individual population that will be enrolled for geographic area utilization relativities, expected provider reimbursement, and utilization management programs.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverage levels.

The Milliman HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

Market-wide rates were developed based on the adjusted MCRM, and we used the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

Adjustments Made to the Data

The following adjustments were made to calibrate the pricing model to the expected population:

-Rating region
-Expected demographics
-Expected morbidity
-Provider Reimbursement
-Expected utilization management savings
-Benefit plan designs

Inclusion of Capitation Payments

Capitated payments for services are accounted for through a PMPM allocation to claims, where the average capitation amount replaces the projected claims amount.

7. Credibility of Experience

Coordinated Care Corporation does not have credible experience on which to base rate development. The product became effective on January 1, 2014. As a result of the immature claims experience and volatile membership to date, there is insufficient claims experience to support premium development. We used a credibility percentage of 0%, for the purposes of the rate projection.

8. Paid to Allowed Ratio

The Paid to Allowed Average Factor in the Projection Period for the market is shown on Worksheet 1, Section III.

This ratio was developed by compositing values from the pricing model by plan. The pricing model that develops the plan cost relativities calculates per member per month costs on both an allowed and paid basis. The paid to allowed ratios for each plan in Worksheet 2 were composited using the projected membership in Worksheet 2. This calculation is shown in Appendix D.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

The first step to developing the risk adjustment transfer payment is to summarize the projected enrollment by age, gender, plan design, and income (relative to the federal poverty level), and make estimates of each component of the risk transfer formula for each enrollment cell. These estimates are then aggregated using projected statewide and Coordinated Care Corporation enrollment to determine the portfolio average risk transfer payment or receivable, which is then proportionally allocated to all plans in the portfolio.

The risk transfer calculations are based on the risk adjustment transfer formula, as provided in the Federal Register Volume 78 Number 47, and displayed below. The "HHS Notice of Benefit and Payment Parameters for 2015", which was made final March 11, 2014, states that the 2015 risk adjustment parameters are the same as those used for the 2014 plan year.

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \overline{P_s}$$

Where:

$\bar{P}_s$= State average premium

$PLRS_t$ = plan i's plan liability risk score;

AV_i= plan i's metal level AV;

ARF_i= plan i's allowable rating factor;

IDF_i = plan i's induced demand factor;

GCF_i = plan i's geographic cost factor;

s_i = plan i's share of State enrollment as measured in member months;
and the denominator is summed across all plans in the risk pool in the market in the State.

For the purpose of our modeling, each of these factors was approximated as follows.

$\overline{P}$: For the State Average Premium, it was assumed the average statewide premium is approximately $426 PMPM.

PLRS: The risk score is approximated as the product of factors from two models:

1) Average Health and Human Services Hierarchical Condition Category (HHS-HCC) Risk Adjustment score by age and gender and metal level AV for the pre-reform Individual Market, developed using Truven Market Scan data;
2) Morbidity of the 2015 statewide Individual Market risk pool and 2015 On-Exchange population morbidity, relative to the pre-reform Individual Market average by age and gender, adjusted for the expected efficiency of the HHS-HCC Risk Adjuster

The HHS-HCC code was adapted from the published rules relating to market reform.

The previous section Credibility Manual Rate Development describes the development of the SIM enrollment and morbidity estimates, based on data and assumptions regarding the distribution of health status by insurance coverage pre-reform and insurance coverage transitions through 2015. The SIM estimates relative morbidity from each population's relative composition by age, gender, and self-reported health status.

IDF: The induced demand factors are provided in the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.

AV: The actuarial value is provided in the March 11, 2013 Federal Register, page 15433, Table 9. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold, 0.80, and Platinum 0.90.

ARF: As stated in the March 11, 2013 Federal Register, page 15433, the allowable rating factor adjustment accounts only for age rating. The adjustment uses the HHS age rating factors blended to the anticipated enrollment age band level. An equal distribution for each age within each age band was assumed.

GCF: No adjustment was assumed for the geographic rating factors.

This calculation results in an estimated per member risk adjustment relativity factor for each enrollment cell, which when multiplied by the state-wide average premium gives the estimated per member per month transfer payment. These transfer payments are then composited over enrollment for all plans to estimate the total and proportionally distributed relative to premium for each plan.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

The 2015 Transitional Reinsurance program payout parameters, applicable to members in the Individual market, are:

- $70,000 claims attachment point
- $250,000 reinsurance cap
- 50% coinsurance rate

The anticipated payments from this temporary program in 2015 are equivalent to approximately 6.9% of premium.

This estimate was derived by considering the claim probability distribution adjusted to reflect the estimated paid PMPM underlying the modified MCRM pricing model, given the payment parameters stated above. HHS will assess $3.67 PMPM to fund the transitional reinsurance program in 2015. The expected transitional reinsurance recovery is $29.69 PMPM. The net reinsurance recovery is then $26.02 PMPM and is allocated proportionally based on plan premiums across all plans.

Temporary Risk Corridor:

No adjustment was made to the Index rate due to the temporary risk corridor program. Although no adjustment was made in pricing for the risk corridor program, it is still possible that risk corridor transfer payments could be made, depending on actual experience. There is risk borne by carriers due to changes and uncertainties in the market stabilization program.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

Based on our membership projections, we have projected that we need $49.11 PMPM to cover administrative expenses. This allowance is estimated to appropriately cover expenses for overhead, operations, sales, distribution, and marketing expenses.

We have estimated an additional $1.88 PMPM to cover approved quality improvement expenses and $2.00 PMPM to cover provider incentive payments.

The administrative expenses are allocated proportionally by plan.

Profit (or Contribution to Surplus) & Risk Margin:

The proposed rates reflect 5.0% of premium as a risk/profit margin. This load was applied to all products and plans.

Taxes and Fees:

The following taxes and fees are included in the non-benefit expenses:

$2.00 Per Member Per Year for the Patient Centered Outcomes Research Fee (0.04% of Premium)
$1.00 Per Member Per Year for the Risk Adjustment User Fee (0.02% of Premium)
3.00% of premium for the Health Insurance Provider Fee
1.30% of premium for State of Indiana Premium Tax assessments
3.50% of premium for Federally Facilitated Exchange fee
0.40% of premium for anticipated assessments (high risk pool)

The Federal transitional reinsurance contribution of $3.67 PMPM is netted out of the reinsurance recoverable, as described in the previous section. It is not included as a non-benefit expense.

11. Projected Medical Loss Ratio

The projected medical loss ratio is 83.8%. This loss ratio is calculated consistently with the federal MLR methodology. See table below for the calculation.

a)	Incurred Claims	$376.19
b)	Risk Adjustment Transfer	($25.52)
c)	Transitional Reinsurance Payment	($29.69)
d)	Adjusted Incurred Claims (a+b+c)	$320.97
e)	Reinsurance Premium	$3.67
f)	Worksheet 1 Projected Incurred Claims (d+e)	$324.64
g)	Administrative Expenses	$49.11
h)	Profit and Contribution to Surplus	$21.54
i)	Taxes and Fees	$35.58
j)	Premium (f+g+h+i)	$430.88
k)	Federal Income Tax	$7.54
l)	State Income Tax	$0.84
m)	Medical Loss Ratio (d/(j-e-i-k-l))	83.8%

The expected Lifetime Loss Ratio is 75.3% [=(f) / (j)].

12. Single Risk Pool

The index rate is based on the Single Risk Pool set by the State of Indiana, which was established according to the requirements in 45 CFR Part 156.80(d). The Single Risk Pool is defined as the non-grandfathered Individual business in Indiana.

13. Index Rate

The Index Rate for the Experience Period has been left blank, since there is not credible experience on which to base the rate development.

The Index Rate for the Projection Period (calendar year 2015) is reflected in Section III, worksheet 1 of the URRT.

The Index Rate for the Projection Period represents the estimated total combined projected allowed claims PMPM for essential health benefits (EHB) for calendar year 2015, and has not been adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees. The total allowed claims include benefits in excess of EHBs (Acupuncture, Adult vision coverage, and Adult dental coverage). Pediatric dental is not included in the benefit package since this will be offered through a stand-alone plan on the Exchange. The index rate was calculated based on the results of the Credibility Manual Rate Development, detailed above. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

The development of the projection Index Rate is found in Section II of worksheet 1. The projection period Index Rate reflects:

- The 12 months projection period shown in Worksheet 1, Section II.
- The anticipated claim level of the projection period with respect to trend, benefit and demographics
- The experience of all policies expected to be in the single risk pool (with necessary adjustments)

Appendix E demonstrates the flow of the rate development from the projection Index Rate to the Consumer Adjusted Premium Rates. The next three sections further describe the steps of the rate development shown in Appendix E.

14. Market Adjusted Index Rates

The Index Rate was then adjusted to arrive at a Market Adjusted Index Rate, based on the following allowable adjustments, as outlined in 45 CFR 156.80(d):

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

The reinsurance and risk adjustments are described above in the Reinsurance and Risk Adjustment section.

The Exchange user fee is 3.5% of premium.

Appendix E shows the development of the Market Adjusted Index Rate.

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rate is the Market Adjusted Index Rate adjusted for any of the following allowable adjustments, where applicable, as outlined in 45 CFR 156.80(d):

- The actuarial value and cost-sharing design of the plan
- Provider network, delivery system and utilization management adjustment
- The benefits provided under the plan that are in addition to the essential health benefits
- Adjustment for distribution and administrative costs

Administrative costs and Other Benefits (non-EHB) common to all plans are added to the Market Adjusted Index Rate and then factors for actuarial value and cost sharing, tobacco surcharge and non-EHBs by plan are applied to reach the Plan Adjusted Index Rates by plan.

The development and values of the Plan Adjusted Index Rates is shown in Appendix E.

16. Calibration

Calibration factors reflecting the allowable rating factors are applied to the Plan Adjusted Index Rates in order to calculate the Consumer Adjusted Premium Rates. The calibration factors for each of the age factors and geographic factors are shown in Appendix E. Note that each of the calibration factors has one value that is applied uniformly and does not vary by plan.

Age Curve Calibration

The age curve calibration factor applied in Appendix E is calculated by weighting the prescribed age rating factors with the single risk pool membership distribution. The age factor for each age band is the simple average of the factors in that band. The weighted average age that corresponds to this age calibration factor is 47 years.

Appendix E of the Actuarial Memorandum demonstrates the step of applying the age calibration factor to the Plan Adjusted Index Rate to get to the Consumer Adjusted Premium Rates.

Geographic Factor Calibration

The geographic rating factors are displayed in Appendix B.

17. Consumer Adjusted Premium Rate Development

Each Plan Adjusted Index Rate is divided by the overall calibration factor to determine the Consumer Adjusted Premium Base Rate.

The following allowable rating factors, as specified by 45 CFR Part 147.102, are applied to the Consumer Adjusted Premium Base Rate to determine the rate that is charged to the health insurance purchaser:

- Rating area
- Age
- Tobacco status
- For family coverage, rates for children are charged to no more than the three oldest covered children under age 21

Appendix B lists the allowable rating factors and has an example calculation of a family's rates.

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I URRT were based on the Federal AV Calculator. Please refer to Appendix F for screen shots documenting the outcomes of the AV Calculator for each plan.

19. AV Pricing Values

For each plan, we have indicated the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2). See Appendix G for this development.

Each plan's AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. The AV Pricing Values reflect the relative impact of the following items:

- The plan's provider network, delivery system characteristics and utilization management
- The actuarial value and cost sharing design of the plan
- The additional expected cost of non-essential health benefits provided under each plan
- Administrative costs, excluding Exchange user fees
- Tobacco surcharge

The benefit relativities were developed using the MCRM, as described in the Credibility Manual Rate Development section. Since these products were first offered effective 1/1/2014, and Coordinated Care Corporation does not have experience on which to base the rate development, the MCRM was used to develop the benefit relativities for the AV Pricing Values.

Market-wide rates were developed based on the MCRM using the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

20. Membership Projections

Statewide individual market enrollment projections were developed from the same State Impact Model (SIM) projections used to estimate individual market morbidity (see the "Credibility Manual Rate Development" section for more details). Coordinated Care Corporation adjusted the projections for specific expectations regarding Medicaid MCO and Health Plan market share. Specifically, adjustments were made to reflect the proportion of enrollees by income selecting a Medicaid MCO that offers individual insurance on the exchange. Of the proportion of enrollment that select a Medicaid MCO offering individual insurance, the Health Plan made assumptions regarding expected membership based on the portion of this segment in each county that is in line with its current market share of Medicaid Managed Care business in that county.

For Silver plan membership, the portion of the projected enrollment that will be eligible for cost sharing reduction subsidies at each subsidy level was based on the income level detail in the enrollment projections. The detail of the projected membership by subsidy level is shown in Appendix H.

21. Terminated Products

No products will be terminated.

22. Plan Type

Not applicable. The Plan types listed in Worksheet 2, Section I of the Part I URRT describe Coordinated Care Corporation's plans exactly.

23. Warning Alerts

There are no warning alerts in the URRT.

24. Effective Rate Review Information

The following section is provided to facilitate rate review by the Indiana Department of Insurance. The content provided follows the section "III Actuarial Memorandum" of the filing instructions named "7.0(A) Qualified Health Plans (QHPs) Individual Rate Requirements for Major Medical, HMO and Dental".

24.1. Benefit Structure

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Coordinated Care Corporation's Individual health block of business, effective January 1, 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT) and the Part II Written Justification.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This actuarial memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene, parent company of Coordinated Care Corporation, and Milliman, Inc. dated January 13, 2003. This information is intended for use by the Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Coordinated Care Corporation's Individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for Coordinated Care Corporation by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions. This is a renewal rate filing. The purpose of this filing is to meet the requirements of the State of Indiana statutes and demonstrate that the benefits are reasonable in relation to the premium charged.

Company Identifying Information:

- Company Legal Name: Coordinated Care Corporation
- Market: Individual
- Prior SERFF Tracking Number: CELT - 128986928

A copy of the policy form is attached as part of this filing.

The benefits provided fall into four categories:

- Essential Health Benefits: All plans provide coverage for the essential health benefits as prescribed through ACA guidance and as covered by the benchmark plan for Indiana.
- State Mandated Benefits Which are Not Essential Health Benefits: There are no state mandated benefits which are not essential health benefits.
- Additional Mandatory Supplemental Benefits: The plans offered under this filing do not include any additional mandatory supplemental benefits.
- Additional Optional Supplemental Benefits: Each medical plan design, as described below, is available with adult vision coverage or with adult vision and adult dental coverage.

This rate filing proposes changes to the previous filing for the base rate, rating factors, non-benefit expenses and the plans offered. The covered benefits have not changed from the previous filing.

These products are HMO health policies issues by Coordinated Care Corporation. Each plan below can be a stand-alone plan, have adult vision coverage, or have both adult vision and adult dental coverage. The major provisions of this form for each plan design and product are as follows:

Plan Design	Med Deductible	Plan Coins	Rx Deductible	OOP Max	PCP Visit	Spec Visit	Rx Copay
Ambetter Secure Care 2	$500	80%	$500	$6350	$50 NSD	$75 NSD	$15 NSD/$30 SD/$100 SD/30% SD / Max $350
Ambetter Secure Care 1 with 3 Free PCP Visits	$1000	80%	$500	$6350	D&C	D&C	$10 NSD/$25 SD/$75 SD/30% SD / Max $350
Ambetter Balanced Care 3	$2500	70%	$1000	$6350	$50 NSD	$75 NSD	$20 NSD/$50 SD/$100 SD/D&C / Max $350
Ambetter Balanced Care 4	$2000 INT	80%	INT	$6350	$50 NSD	$75 NSD	$20 NSD/$50 NSD/$100 SD/D&C
Ambetter Balanced Care 5	$3000	100%	$1000	$6350	$50 NSD	$75 NSD	$10 NSD/$50 SD/$75 SD/$250 SD
Ambetter Balanced Care 1	$5000	70%	$750	$6350	$25 NSD	$50 NSD	$10 NSD/$60 SD/50% SD/50% SD
Ambetter Balanced Care 2	$5000 INT	100%	INT	$5000	$30 NSD	$60 NSD	$10 NSD/$50 NSD/D&C/D&C
Ambetter Essential Care 2	$5000 INT	60%	INT	$6500	D&C	D&C	$25 NSD/$50 SD/$100 SD/D&C
Ambetter Essential Care 1	$6500 INT	100%	INT	$6500	D&C	D&C	$20 NSD/D&C/D&C /D&C

Ambetter Essential Care 3 with 3 Free PCP Visits	$6000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$50 SD/$100 SD/30% SD / Max $350
Ambetter Essential Care 4 with 3 Free PCP Visits	$4000 INT	60%	INT	$6350	D&C	D&C	$25 NSD/$100 SD/$150 SD/30% SD / Max $350

D&C – Deductible and Coinsurance

INT – Integrated Medical and Rx Deductible

NSD – Not subject to deductible

SD – Subject to deductible

Rx Copay – Generic / Preferred Brand / Non-Preferred Brand / Specialty

24.2. Current Rates

The current rates are attached in the form of the 2014 Federal Rate Template. Premiums are collected only on a monthly basis. The current rates do not change during the rating period. The current geographic rating factors are consistent with the expected unit cost differences between areas. The current rates are charged on an individual basis. For family coverage, rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Affordable Care Act. The policyholder's premium payment under the current rates is impacted by the following factors:

- Geography
- Tobacco
- Age
- Plan Design

24.3. Proposed Rates

The proposed rates are attached in the form of the 2015 Federal Rate Template. Premiums will be collected only on a monthly basis. The proposed rates do not change during the rating period. The geographic factors are developed based upon contractual reimbursement differences and expected utilization differences in each of the established rating areas. Based upon the expected distribution of enrollment by area, the geographic factors reflect the single risk pool results consistent with the URRT. The geographic factors for unit cost and utilization differences within the manual rate model vary by Metropolitan Service Area (MSA), and are a component to the geographic factor. To the extent the established rating area is a subset of an MSA, the manual rate model geographic factors are supplemented with county specific unit cost relativities. The attached rate schedule is reflective of the geographic rating factors. The proposed rates are charged on an individual basis. For family coverage,

rates for children are charged to no more than the three oldest covered children under age 21, consistent with the Affordable Care Act. The policyholder's premium payment under the current rates is impacted by the following factors:

- Geography
- Tobacco
- Age
- Plan Design

The policyholder's premium payment under the proposed rates is not impacted by changes in morbidity, additional mandates, or other factors.

24.4. Projected Experience with Requested Rate Change
Appendix K demonstrates the projected experience with the requested rate change.

24.5. Projected Experience without Requested Rate Change
Appendix K demonstrates the projected experience without the requested rate change.

24.6. Assumptions
The annual per individual rate of medical cost increase assumed for the next year is equal to 4.4%. The annual per individual rate of premium increase assumed for the next year is equal to -8.8%.

24.7. Premium Guarantee Provision
The proposed rates are guaranteed not to change through December 31, 2015.

24.8. Rating Factors
In accordance with the Affordable Care Act, rates may vary by age, geographic area, tobacco use and benefit plan. Rates are charged on an individual basis. For family coverage, rates for children are charged for no more than the three oldest covered children under age 21. Appendix B includes the base rate and allowable rating factors.

Administrative Expense Load: Based on our membership projections, we have projected that we need $49.11 PMPM to cover administrative expenses. This allowance is estimated to appropriately cover expenses for overhead, operations, sales, distribution, and marketing expenses.

We have estimated an additional $1.88 PMPM to cover approved quality improvement expenses and $2.00 PMPM to cover provider incentive payments.

The administrative expenses are allocated proportionally by plan.

Profit (or Contribution to Surplus) & Risk Margin: The proposed rates reflect 5.0% of premium as a risk/profit margin. This load was applied to all products and plans.

The following taxes and fees are included in the non-benefit expenses:

$2.00 Per Member Per Year for the Patient Centered Outcomes Research Fee (0.04% of Premium)
$1.00 Per Member Per Year for the Risk Adjustment User Fee (0.02% of Premium)
3.00% of premium for the Health Insurance Provider Fee
1.30% of premium for State of Indiana Premium Tax assessments
3.50% of premium for Federally Facilitated Exchange fee
0.40% of premium for anticipated assessments

The Federal transitional reinsurance contribution of $3.67 PMPM is netted out of the reinsurance recoverable, as described in the previous section. It is not included as a non-benefit expense.

The impact of contractual agreements with health care providers and administrators is factored into the geographic area factors.

24.9. Historical Experience

Note that the products to which this rate filing applies were initially offered effective 1/1/2014. As a result, experience data is limited. The following table reflects the available membership and premium data available, through 2/28/2014.

Month	Membership	Premium Revenue
1/2014	179	$90,721
2/2014	251	$126,860

24.10. Projection of Lifetime Target Loss Ratio

The target loss ratio is projected over the next five years and beyond in the exhibit, 'Projection of Lifetime Target Loss Ratio'. Note that experience period data is not available due to the current benefits being offered for the first time on 1/1/2014. The first policy year refers to 2015. Note that proposed rates are resubmitted each year, so the actual expected future lifetime of the policies affected is only one year.

24.11. Company Financial Position

See Appendix I for documents summarizing the capital and surplus position of Coordinated Care Corporation.

25. Reliance

In the preparation of this filing, I relied upon data provided under the direction of Charles Kearns, Centene. I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

See Appendix J for a listing of items received for the rate development.

26. Actuarial Certification

I, Jason T. Nowakowski, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This filing is prepared on behalf of Coordinated Care Corporation (the "Company") to comply with applicable State and Federal Statutes for Individual Rate Filings.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I certify that this filing has been prepared in accordance with the following:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

I certify that the projected Index Rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Actuarially sound and developed in compliance with the applicable Actuarial Standards of Practice. For the purposes of this certification, actuarially sound is defined as, in consideration of expected reinsurance cash flows, risk adjustment cash flows, and investment income, containing adequate provision for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the essential health benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans. The AV Metal Values included in Worksheet 2 in Part I URRT were based on the Federal AV Calculator.

I certify that rates are charged to no more than the three oldest covered children under 21 for a family coverage.

I certify that, to the best of my knowledge and understanding, the proposed rates are in compliance with requirements under 45 CFR Subpart E (Section 156.400 through 156.470) and Coordinated Care Corporation intends to use the methodology outlined by HHS for advanced Cost-Sharing Reduction payments.

The Part I URRT does not demonstrate the process used by Coordinated Care Corporation to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

I certify that this rate filing was prepared in compliance with all applicable state and federal statutes and regulations.

I certify that this rate filing was prepared in compliance with Actuarial Standards of Practice (ASOP).

Signed: Jason T. Nowakowski

Name: Jason T. Nowakowski

Title: Principal & Consulting Actuary

Date: May 7, 2014

This document is a trade secret and needs to be kept confidential from the public realm.

Appendix A
Coordinated Care Corporation
Age and Rating Area Distributions

Age Band	Percent Distribution
0-20	7.24%
21	1.44%
22	1.44%
23	1.44%
24	1.44%
25	2.08%
26	2.08%
27	2.08%
28	2.08%
29	2.08%
30	2.07%
31	2.07%
32	2.07%
33	2.07%
34	2.07%
35	2.16%
36	2.16%
37	2.16%
38	2.16%
39	2.16%
40	2.24%
41	2.24%
42	2.24%
43	2.24%
44	2.24%
45	2.21%
46	2.21%
47	2.21%
48	2.21%
49	2.21%
50	2.00%
51	2.00%
52	2.00%
53	2.00%
54	2.00%
55	2.49%
56	2.49%
57	2.49%
58	2.49%
59	2.49%
60	2.15%
61	2.15%
62	2.15%
63	2.15%
64	2.15%
65 and Over	0.00%

Rating Area	Percent Distribution
Rating Area 1	15.5%
Rating Area 2	8.7%
Rating Area 3	6.9%
Rating Area 4	8.6%
Rating Area 6	2.8%
Rating Area 10	39.7%
Rating Area 11	7.8%
Rating Area 13	3.4%
Rating Area 15	3.2%
Rating Area 16	3.3%

Appendix B
Coordinated Care Corporation
Rate Table

Base Rate	$280.72

Product Adjustment	
Product	**PMPM Adj**
35065IN001 (Appies to all plans)	$0.00
35065IN002 (Appies to all plans)	$4.66
35065IN003 (Appies to all plans)	$16.33

Plan	Rate Factor
Ambetter Secure Care 2	1.168
Ambetter Secure Care 1 with 3 Free PCP Visits	1.150
Ambetter Balanced Care 3	0.998
Ambetter Balanced Care 4	0.972
Ambetter Balanced Care 5	1.000
Ambetter Balanced Care 1	0.962
Ambetter Balanced Care 2	0.924
Ambetter Essential Care 2	0.766
Ambetter Essential Care 1	0.755
Ambetter Essential Care 3 with 3 Free PCP Visits	0.769
Ambetter Essential Care 4 with 3 Free PCP Visits	0.801

Age Band	Age Factor	Tobacco Factors	
		Smoker	Non-Smoker
0-20	0.635	1.155	1.000
21	1.000	1.155	1.000
22	1.000	1.155	1.000
23	1.000	1.155	1.000
24	1.000	1.155	1.000
25	1.004	1.085	1.000
26	1.024	1.085	1.000
27	1.048	1.085	1.000
28	1.087	1.085	1.000
29	1.119	1.085	1.000
30	1.135	1.085	1.000
31	1.159	1.085	1.000
32	1.183	1.085	1.000
33	1.198	1.085	1.000
34	1.214	1.085	1.000
35	1.222	1.055	1.000
36	1.230	1.055	1.000
37	1.238	1.055	1.000
38	1.246	1.055	1.000
39	1.262	1.055	1.000
40	1.278	1.102	1.000
41	1.302	1.132	1.000
42	1.325	1.162	1.000
43	1.357	1.192	1.000
44	1.397	1.222	1.000
45	1.444	1.172	1.000
46	1.500	1.212	1.000
47	1.563	1.252	1.000
48	1.635	1.292	1.000
49	1.706	1.332	1.000
50	1.786	1.455	1.000
51	1.865	1.415	1.000
52	1.952	1.375	1.000
53	2.040	1.335	1.000
54	2.135	1.295	1.000
55	2.230	1.250	1.000
56	2.333	1.225	1.000
57	2.437	1.200	1.000
58	2.548	1.175	1.000
59	2.603	1.150	1.000
60	2.714	1.120	1.000
61	2.810	1.105	1.000
62	2.873	1.090	1.000
63	2.952	1.075	1.000
64	3.000	1.060	1.000
65 and Over	3.000	1.060	1.000

Geographic Factors	
Area	**Rate Factor**
Rating Area 1	0.952
Rating Area 2	1.035
Rating Area 3	0.871
Rating Area 4	0.835
Rating Area 6	0.962
Rating Area 10	1.079
Rating Area 11	1.086
Rating Area 13	1.231
Rating Area 15	0.820
Rating Area 16	0.655

Appendix B
Coordinated Care Corporation
Rating Example

Family Rating Example

Plan Design:	Ambetter Secure Care 2
Product:	35065IN001

Member	Age	Smoking Status	Rating Area	(a) Base	(b) Prod. Adj.	(c) Plan Rate Factor	(d) = ((a) + (b)) x (c) Consumer Adjusted Premium Rate	(e) Age Factor	(f) Tobacco	(g) Area	(h) = (d) x (e) x (f) x (g) Final Premium
Subscriber	40	Non-Smoker	Rating Area 1	$280.72	$0.00	1.168	$327.88	1.278	1.000	0.952	$398.92
Spouse	38	Non-Smoker	Rating Area 1	280.72	0.00	1.168	327.88	1.246	1.000	0.952	388.93
Child 1	18	Non-Smoker	Rating Area 1	280.72	0.00	1.168	327.88	0.635	1.000	0.952	198.21
Child 2	16	Non-Smoker	Rating Area 1	280.72	0.00	1.168	327.88	0.635	1.000	0.952	198.21
Child 3	14	Non-Smoker	Rating Area 1	280.72	0.00	1.168	327.88	0.635	1.000	0.952	198.21
Child 4	11	Non-Smoker	Rating Area 1	280.72	0.00	1.168	327.88	0.000	1.000	0.952	0.00
Total											**$1,382.48**

(1) Look up the plan rate factor based on the plan design.
(2) Multiply the plan's base rate by the plan rate factor to calculate the Consumer Adjusted Premium Rate.
(3) Look up the age factors for each member based on age.
Note that premiums can only be charged for the first 3 children, so the age factor for all subsequent children will be 0.
(4) Look up the tobacco factor for each member according to smoking status and age.
(5) Look up the area factor based on the rating area.
(6) Multiply the Consumer Adjusted Premium Rate by the age, tobacco and area factors for each member individually.
(7) Sum the results from (6) for the final premium for the family.

Appendix C
Coordinated Care Corporation
Benefit Category Mapping

MCRM Benefit Category	URRT Benefit Category
Inpatient Facility - Non-Maternity	
Medical	Inpatient Hospital
Medical - Other Newborn	Inpatient Hospital
Surgical	Inpatient Hospital
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Inpatient Facility - Maternity	
Deliveries	Inpatient Hospital
Non-Deliveries	Inpatient Hospital
Skilled Nursing Facility	Inpatient Hospital
Outpatient Facility	
Emergency Room	Outpatient Hospital
Surgery	Outpatient Hospital
Radiology	
Radiology - General	Outpatient Hospital
Radiology - CT / MRI / PET	Outpatient Hospital
Pathology/Lab	Outpatient Hospital
Pharmacy	Outpatient Hospital
Cardiovascular	Outpatient Hospital
PT/OT/ST	Outpatient Hospital
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Preventive	Outpatient Hospital
Other Outpatient Facility	Outpatient Hospital
Professional	
Inpatient Surgery - Non-Maternity	
Surgeon	Professional
Anesthesia	Professional
Maternity	
Non-Anesthesia	Professional
Anesthesia	Professional
Outpatient Surgery	
Outpatient Facility	Professional
Office	Professional
Anesthesia	Professional
Inpatient Visits	
Medical	Professional
Psychiatric	Capitation
Alcohol & Drug Abuse	Capitation
Office Visits & Miscellaneous Services	
Office/Home Visits	Professional
Urgent Care Visits	Professional
Office Administered Drugs	Professional
Allergy Testing	Professional
Allergy Immunotherapy	Professional
Miscellaneous Medical	Professional

Appendix C
Coordinated Care Corporation
Benefit Category Mapping

MCRM Benefit Category	URRT Benefit Category
Preventive Services	
Immunizations	Professional
Well Baby Exams	Professional
Physical Exams	Professional
Other Preventive	Professional
Other Professional Services	
ER Visits and Observation Care	Professional
Consults	Professional
Vision Exams	Professional
Hearing and Speech Exams	Professional
Physical Therapy	Professional
Cardiovascular	Professional
Radiology	
Inpatient	Professional
Outpatient	
Outpatient - General	Professional
Outpatient - CT / MRI / PET	Professional
Office	
Office - General	Professional
Office - CT / MRI / PET	Professional
Pathology/Lab	
Inpatient & Outpatient	Professional
Office	Professional
Chiropractor	Professional
Outpatient Psychiatric	Capitation
Outpatient Alcohol & Drug Abuse	Capitation
Other	
Prescription Drugs	Prescription Drug
Private Duty Nursing/Home Health	Other Medical
Ambulance	Other Medical
DME and Supplies	Other Medical
Prosthetics	Other Medical
OptiCare - Child - Exam / Hardware	Capitation
OptiCare - Child - Med / Surg	Capitation
OptiCare - Adult - Med / Surg	Capitation
Cenpatico	Capitation
Nurtur	Capitation
Nursewise	Capitation
Teladoc	Capitation
Start Smart	Capitation
Acupuncture	Professional
Abortion	Professional
Habilitation Services	Professional

Appendix D
Coordinated Care Corporation
Development of Paid to Allowed Ratio

Product	Plan Name	PlanID	(a) Member Months	(b) Allowed Claims PMPM	(c) Paid Claims PMPM	(d) = (c) / (b) Paid to Allowed Ratio
		Aggregate	**147,869**	**$527.59**	**$372.31**	**0.706**
Ambetter	Ambetter Secure Care 2	35065IN0010002	1,472	$548.74	$447.17	0.815
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	490	553.33	441.23	0.797
Ambetter	Ambetter Balanced Care 3	35065IN0010007	2,366	529.55	395.05	0.746
Ambetter	Ambetter Balanced Care 4	35065IN0010008	8,307	520.53	373.20	0.717
Ambetter	Ambetter Balanced Care 5	35065IN0010009	7,099	527.19	394.28	0.748
Ambetter	Ambetter Balanced Care 1	35065IN0010015	11,076	532.07	391.56	0.736
Ambetter	Ambetter Balanced Care 2	35065IN0010014	18,473	536.66	369.99	0.689
Ambetter	Ambetter Essential Care 2	35065IN0010016	3,686	462.62	287.17	0.621
Ambetter	Ambetter Essential Care 1	35065IN0010017	5,898	467.38	283.06	0.606
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	3,686	463.76	288.40	0.622
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	1,474	470.22	300.35	0.639
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	264	$554.33	$452.76	0.817
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	88	558.93	446.83	0.799
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	551	535.11	400.61	0.749
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	1,794	526.09	378.76	0.720
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	1,651	532.75	399.84	0.751
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	2,667	537.63	397.11	0.739
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	4,341	542.21	375.54	0.693
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	749	468.15	292.70	0.625
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	1,199	472.91	288.59	0.610
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	749	469.29	293.93	0.626
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	300	475.75	305.88	0.643
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1,181	$569.22	$467.65	0.822
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	394	573.80	461.71	0.805
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	2,692	549.89	415.40	0.755
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	8,571	540.87	393.55	0.728
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	8,079	547.54	414.63	0.757
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	13,199	552.40	411.88	0.746
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	21,325	556.97	390.30	0.701
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	3,512	482.87	307.42	0.637
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	5,619	487.63	303.30	0.622
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	3,512	484.01	308.65	0.638
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	1,405	490.49	320.62	0.654

Appendix E
Coordinated Care Corporation
Index Rate to Base Rate

			Notes
(a)	**Projected Index Rate PMPM**	$517.50	Total EHB Allowed Charges (Index Rate)
	Market Adjustments		
(b)	Net Risk Adjustment Transfer Paid/(Received)	($25.44)	Includes Risk Adjustment Admin Fee.
(c)	Net Transitional Reinsurance Payment/(Received)	(25.34)	Total composite reinsurance impact on claims, net of reinsurance premium ($3.67).
(d)	Exchange User Fees	14.65	
(e) = (a) + .. + (d)	**Market Adjusted Index Rate**	$481.37	
	Plan Adjustments		
(f)	Member Cost Sharing	($86.57)	
(g)	Silver Plan Cost Sharing Reduction Subsidy	(68.71)	
(h)	SG&A	51.69	
(i)	Profit Margin	12.79	Assumption: 5% profit margin before Federal and State Income Taxes. This does not include the $0.38 profit margin on buy-ups.
(j)	Licensing, Taxes and Fees	27.98	
(k)	Other Benefits Common to All Plans	-	
(l) = (e) + ... + (k)	**Index Rate before Plan Factor Adjustment**	$418.55	

Plan ID	Plan Name	*(1)* Member Months	*(2) = (l)* Index Rate before Plan Factor Adj	*(3)* Actuarial Value and Cost Sharing Adjustment	*(4)* Non-EHB Adjustment [1]	*(5)* Tobacco Surcharge	*(6) = (2) * (3) * (4) * (5)* Plan Adjusted Index Rate	*(7) = (t)* Calibration	*(8) = (6) / (7)* Consumer Adjusted Premium Rate
35065IN0010002	Ambetter Secure Care 2	1,472	$418.55	1.268	1.000	0.987	$524.11	1.599	$327.80
35065IN0010004	Ambetter Secure Care 1 with 3 Free PCP Visits	490	418.55	1.249	1.000	0.987	516.05	1.599	322.76
35065IN0010007	Ambetter Balanced Care 3	2,366	418.55	1.084	1.000	0.987	447.91	1.599	280.14
35065IN0010008	Ambetter Balanced Care 4	8,307	418.55	1.056	1.000	0.987	436.20	1.599	272.81
35065IN0010009	Ambetter Balanced Care 5	7,099	418.55	1.086	1.000	0.987	448.84	1.599	280.72
35065IN0010015	Ambetter Balanced Care 1	11,076	418.55	1.045	1.000	0.987	431.59	1.599	269.93
35065IN0010014	Ambetter Balanced Care 2	18,473	418.55	1.004	1.000	0.987	414.68	1.599	259.35
35065IN0010016	Ambetter Essential Care 2	3,686	418.55	0.832	1.000	0.987	343.65	1.599	214.93
35065IN0010017	Ambetter Essential Care 1	5,898	418.55	0.820	1.000	0.987	338.80	1.599	211.90
35065IN0010012	Ambetter Essential Care 3 with 3 Free PCP Visits	3,686	418.55	0.835	1.000	0.987	345.20	1.599	215.90
35065IN0010013	Ambetter Essential Care 4 with 3 Free PCP Visits	1,474	418.55	0.870	1.000	0.987	359.66	1.599	224.94
35065IN0020002	Ambetter Secure Care 2 + Vision	264	418.55	1.268	1.014	0.987	531.45	1.599	332.39
35065IN0020004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	88	418.55	1.249	1.014	0.987	523.36	1.599	327.33
35065IN0020007	Ambetter Balanced Care 3 + Vision	551	418.55	1.084	1.016	0.987	454.99	1.599	284.57
35065IN0020008	Ambetter Balanced Care 4 + Vision	1,794	418.55	1.056	1.016	0.987	443.25	1.599	277.23
35065IN0020009	Ambetter Balanced Care 5 + Vision	1,651	418.55	1.086	1.016	0.987	455.93	1.599	285.15
35065IN0020015	Ambetter Balanced Care 1 + Vision	2,667	418.55	1.045	1.016	0.987	438.62	1.599	274.33
35065IN0020014	Ambetter Balanced Care 2 + Vision	4,341	418.55	1.004	1.017	0.987	421.66	1.599	263.72
35065IN0020016	Ambetter Essential Care 2 + Vision	749	418.55	0.832	1.020	0.987	350.37	1.599	219.13
35065IN0020017	Ambetter Essential Care 1 + Vision	1,199	418.55	0.820	1.020	0.987	345.51	1.599	216.10
35065IN0020012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	749	418.55	0.835	1.019	0.987	351.92	1.599	220.10
35065IN0020013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	300	418.55	0.870	1.019	0.987	366.42	1.599	229.18
35065IN0030002	Ambetter Secure Care 2 + Vision + Adult Dental	1,181	418.55	1.268	1.049	0.987	549.86	1.599	343.90
35065IN0030004	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	394	418.55	1.249	1.050	0.987	541.68	1.599	338.79
35065IN0030007	Ambetter Balanced Care 3 + Vision + Adult Dental	2,692	418.55	1.084	1.055	0.987	472.74	1.599	295.67
35065IN0030008	Ambetter Balanced Care 4 + Vision + Adult Dental	8,571	418.55	1.056	1.057	0.987	460.93	1.599	288.28
35065IN0030009	Ambetter Balanced Care 5 + Vision + Adult Dental	8,079	418.55	1.086	1.055	0.987	473.71	1.599	296.27
35065IN0030015	Ambetter Balanced Care 1 + Vision + Adult Dental	13,199	418.55	1.045	1.057	0.987	456.25	1.599	285.36
35065IN0030014	Ambetter Balanced Care 2 + Vision + Adult Dental	21,325	418.55	1.004	1.059	0.987	439.18	1.599	274.68
35065IN0030016	Ambetter Essential Care 2 + Vision + Adult Dental	3,512	418.55	0.832	1.068	0.987	367.18	1.599	229.65
35065IN0030017	Ambetter Essential Care 1 + Vision + Adult Dental	5,619	418.55	0.820	1.069	0.987	362.32	1.599	226.61
35065IN0030012	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	3,512	418.55	0.835	1.068	0.987	368.73	1.599	230.62
35065IN0030013	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	1,405	418.55	0.870	1.066	0.987	383.36	1.599	239.77
Total		147,869	$418.55	1.000	1.030	0.987	$425.36	1.599	$266.03

(m) = (8)	Consumer Adjusted Index Rate	$266.03	
(n)	Composite Plan Factor	0.948	
(o)	Interaction [2]	1.000	
(p) = (m) / (n)	**Base Rate (= Appendix B.1 "Base Rate")**	$280.72	
	Calibration		
(q)	Composite Area Factor	1.000	
(r)	Composite Age Factor	1.598	The weighted average age is 47.
(s)	Interaction [3]	1.000	
(t) = (q) * (r) * (s)	**Calibration**	1.599	

Notes:
(1) Non-EHB Adjustment includes impacts to SG&A and profit margin due to offering Adult Vision.
(2) The interaction term accounts for the interdependence of the tobacco and plan factors (EHB and Non-EHB).
(3) The interaction term accounts for the interdependence of the area, age, tobacco and plan factors.

Appendix F
Coordinated Care Corporation
AV Calculator Results

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.3%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	70.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.88%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	70.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.87%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$150.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	95.00%	70.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$2.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$5.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.46%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.67%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.85%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.90%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$100.00			
Coinsurance (%, Insurer's Cost Share)			95.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☐	☐		$5.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.79%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$1,000.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☑	☑		
Specialist Visit	☐	☐		$75.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$250.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$5,200.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$150.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	91%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.2%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$10.00	☑	☑		
Skilled Nursing Facility	☑	☐		$100.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	97%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.97%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$2,250.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$50.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$25.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	97%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$100.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$750.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.49%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$1,750.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%	
OOP Maximum ($)	$5,200.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.90%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$150.00	$150.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%	
OOP Maximum ($)	$2,250.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.81%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	50.00%				
OOP Maximum ($)	$750.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.77%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$5,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.65%
Metal Tier:	Silver

Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.75%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☑		$1.00	☑	☑		
Preferred Brand Drugs	☐	☑		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.65%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$1.00	☑	☑		
Specialist Visit	☐	☐		$5.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$1.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$1.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.81%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.89%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.24%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.57%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
			Combined	Medical	Drug	Combined
Deductible ($)			$4,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$150.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$350
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.64%
Metal Tier:	Bronze

Appendix G
Coordinated Care Corporation
AV Pricing Value Allocation

Product	Plan Name	PlanID	Pricing AV	Provider Network, Delivery System and Utilization Management	Actuarial Value and Cost Sharing Adjustment	Non-EHB Benefits	Tobacco Surcharge	Administrative Cost
Ambetter	Ambetter Secure Care 2	35065IN0010002	1.089	1.000	0.859	1.000	0.987	1.284
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	1.072	1.000	0.846	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 3	35065IN0010007	0.930	1.000	0.734	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 4	35065IN0010008	0.906	1.000	0.715	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 5	35065IN0010009	0.932	1.000	0.736	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 1	35065IN0010015	0.897	1.000	0.708	1.000	0.987	1.284
Ambetter	Ambetter Balanced Care 2	35065IN0010014	0.861	1.000	0.680	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 2	35065IN0010016	0.714	1.000	0.563	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 1	35065IN0010017	0.704	1.000	0.555	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	0.717	1.000	0.566	1.000	0.987	1.284
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	0.747	1.000	0.590	1.000	0.987	1.284
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	1.104	1.000	0.859	1.014	0.987	1.284
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	1.087	1.000	0.846	1.014	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	0.945	1.000	0.734	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	0.921	1.000	0.715	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	0.947	1.000	0.736	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	0.911	1.000	0.708	1.016	0.987	1.284
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	0.876	1.000	0.680	1.017	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	0.728	1.000	0.563	1.020	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	0.718	1.000	0.555	1.020	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	0.731	1.000	0.566	1.019	0.987	1.284
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	0.761	1.000	0.590	1.019	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1.142	1.000	0.859	1.049	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	1.125	1.000	0.846	1.050	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	0.982	1.000	0.734	1.055	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	0.958	1.000	0.715	1.057	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	0.984	1.000	0.736	1.055	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	0.948	1.000	0.708	1.057	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	0.912	1.000	0.680	1.059	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	0.763	1.000	0.563	1.068	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	0.753	1.000	0.555	1.069	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	0.766	1.000	0.566	1.068	0.987	1.284
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	0.796	1.000	0.590	1.066	0.987	1.284

Appendix H
Coordinated Care Corporation
Membership Projections

			Member Months						
				Silver Plan					
Product	**Plan Name**	**Plan ID**	**Gold**	**70%**	**73%**	**87%**	**94%**	**Bronze**	**Total**
		Aggregate	**3,889**	**12,966**	**11,240**	**39,246**	**48,739**	**31,789**	**147,869**
Ambetter	Ambetter Secure Care 2	35065IN0010002	1,472	-	-	-	-	-	1,472
Ambetter	Ambetter Secure Care 1 with 3 Free PCP Visits	35065IN0010004	490	-	-	-	-	-	490
Ambetter	Ambetter Balanced Care 3	35065IN0010007	-	328	278	785	975	-	2,366
Ambetter	Ambetter Balanced Care 4	35065IN0010008	-	1,969	2,224	3,139	975	-	8,307
Ambetter	Ambetter Balanced Care 5	35065IN0010009	-	985	834	2,355	2,925	-	7,099
Ambetter	Ambetter Balanced Care 1	35065IN0010015	-	657	834	4,710	4,875	-	11,076
Ambetter	Ambetter Balanced Care 2	35065IN0010014	-	2,626	1,390	4,710	9,747	-	18,473
Ambetter	Ambetter Essential Care 2	35065IN0010016	-	-	-	-	-	3,686	3,686
Ambetter	Ambetter Essential Care 1	35065IN0010017	-	-	-	-	-	5,898	5,898
Ambetter	Ambetter Essential Care 3 with 3 Free PCP Visits	35065IN0010012	-	-	-	-	-	3,686	3,686
Ambetter	Ambetter Essential Care 4 with 3 Free PCP Visits	35065IN0010013	-	-	-	-	-	1,474	1,474
Ambetter + Vision	Ambetter Secure Care 2 + Vision	35065IN0020002	264	-	-	-	-	-	264
Ambetter + Vision	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision	35065IN0020004	88	-	-	-	-	-	88
Ambetter + Vision	Ambetter Balanced Care 3 + Vision	35065IN0020007	-	59	52	196	244	-	551
Ambetter + Vision	Ambetter Balanced Care 4 + Vision	35065IN0020008	-	352	413	785	244	-	1,794
Ambetter + Vision	Ambetter Balanced Care 5 + Vision	35065IN0020009	-	176	155	589	731	-	1,651
Ambetter + Vision	Ambetter Balanced Care 1 + Vision	35065IN0020015	-	117	155	1,177	1,218	-	2,667
Ambetter + Vision	Ambetter Balanced Care 2 + Vision	35065IN0020014	-	469	258	1,177	2,437	-	4,341
Ambetter + Vision	Ambetter Essential Care 2 + Vision	35065IN0020016	-	-	-	-	-	749	749
Ambetter + Vision	Ambetter Essential Care 1 + Vision	35065IN0020017	-	-	-	-	-	1,199	1,199
Ambetter + Vision	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision	35065IN0020012	-	-	-	-	-	749	749
Ambetter + Vision	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision	35065IN0020013	-	-	-	-	-	300	300
Ambetter + Vision + Adult Dental	Ambetter Secure Care 2 + Vision + Adult Dental	35065IN0030002	1,181	-	-	-	-	-	1,181
Ambetter + Vision + Adult Dental	Ambetter Secure Care 1 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030004	394	-	-	-	-	-	394
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 3 + Vision + Adult Dental	35065IN0030007	-	261	232	981	1,218	-	2,692
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 4 + Vision + Adult Dental	35065IN0030008	-	1,569	1,859	3,925	1,218	-	8,571
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 5 + Vision + Adult Dental	35065IN0030009	-	784	697	2,943	3,655	-	8,079
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 1 + Vision + Adult Dental	35065IN0030015	-	523	697	5,887	6,092	-	13,199
Ambetter + Vision + Adult Dental	Ambetter Balanced Care 2 + Vision + Adult Dental	35065IN0030014	-	2,091	1,162	5,887	12,185	-	21,325
Ambetter + Vision + Adult Dental	Ambetter Essential Care 2 + Vision + Adult Dental	35065IN0030016	-	-	-	-	-	3,512	3,512
Ambetter + Vision + Adult Dental	Ambetter Essential Care 1 + Vision + Adult Dental	35065IN0030017	-	-	-	-	-	5,619	5,619
Ambetter + Vision + Adult Dental	Ambetter Essential Care 3 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030012	-	-	-	-	-	3,512	3,512
Ambetter + Vision + Adult Dental	Ambetter Essential Care 4 with 3 Free PCP Visits + Vision + Adult Dental	35065IN0030013	-	-	-	-	-	1,405	1,405

Appendix I
Coordinated Care Corporation
Capital, Surplus and RBC

ASSETS

	Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1. Bonds (Schedule D)	71,141,230		71,141,230	42,130,488
2. Stocks (Schedule D):				
2.1 Preferred stocks	0		0	0
2.2 Common stocks	10,013,713		10,013,713	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ ..... encumbrances)			0	0
4.2 Properties held for the production of income (less $ ..... encumbrances)			0	0
4.3 Properties held for sale (less $ ..... encumbrances)			0	0
5. Cash ($ 43,301,901 , Schedule E-Part 1), cash equivalents ($ 0 , Schedule E-Part 2) and short-term investments ($ 44,427,016 , Schedule DA)	87,728,917		87,728,917	88,176,976
6. Contract loans (including $ ..... premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)	1,653,392		1,653,392	1,299,177
9. Receivables for securities			0	5,000
10. Securities lending reinvested collateral assets (Schedule DL)			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	170,537,252	0	170,537,252	131,611,641
13. Title plants less $ ..... charged off (for Title insurers only)			0	0
14. Investment income due and accrued	473,403		473,403	464,665
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	4,882,895		4,882,895	11,897,969
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums			0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	1,209,054		1,209,054	745,177
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans			0	0
18.1 Current federal and foreign income tax recoverable and interest thereon			0	0
18.2 Net deferred tax asset	5,403,936		5,403,936	3,710,600
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software			0	0
21. Furniture and equipment, including health care delivery assets ($ .....)			0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	2,392		2,392	67,257
24. Health care ($ 106,095) and other amounts receivable	809,520	703,425	106,095	41,976
25. Aggregate write-ins for other than invested assets	5,778,278	122,933	5,655,345	5,553,078
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	189,096,730	826,358	188,270,372	154,092,363
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	189,096,730	826,358	188,270,372	154,092,363
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. Prepaid Expenses	122,933	122,933	0	0
2502. Company-owned life insurance	5,346,469		5,346,469	5,223,255
2503. State Income tax receivable	308,876		308,876	329,823
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	5,778,278	122,933	5,655,345	5,553,078

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	Current Year 2 Uncovered	Current Year 3 Total	Prior Year 4 Total
1. Claims unpaid (less $ 2,261,521 reinsurance ceded)	66,623,379		66,623,379	52,689,614
2. Accrued medical incentive pool and bonus amounts	6,726,935		6,726,935	2,946,531
3. Unpaid claims adjustment expenses	1,121,000		1,121,000	1,150,000
4. Aggregate health policy reserves, including the liability of $ for medical loss ratio rebate per the Public Health Service Act	8,164,161		8,164,161	4,679,976
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance	25,438,117		25,438,117	23,291,195
9. General expenses due or accrued	6,125,364		6,125,364	14,290,652
10.1 Current federal and foreign income tax payable and interest thereon (including $ on realized capital gains (losses))	3,151,891		3,151,891	3,937,398
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others			0	0
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ current) and interest thereon $ (including $ current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	776,471		776,471	142,708
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ authorized reinsurers, $ unauthorized reinsurers and $ certified reinsurers)			0	0
20. Reinsurance in unauthorized and certified ($) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ current)	13,045,633	0	13,045,633	7,742
24. Total liabilities (Lines 1 to 23)	131,172,951	0	131,172,951	103,135,816
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	545,000	545,000
27. Preferred capital stock	XXX	XXX		0
28. Gross paid in and contributed surplus	XXX	XXX	21,700,000	21,700,000
29. Surplus notes	XXX	XXX		0
30. Aggregate write-ins for other-than-special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	34,852,421	28,711,547
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 $)	XXX	XXX		0
32.2 shares preferred (value included in Line 27 $)	XXX	XXX		0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	57,097,421	50,956,547
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	188,270,372	154,092,363
DETAILS OF WRITE-INS				
2301. State Income Tax Payable			0	7,742
2302. Washington Premium Adjustment	13,045,633		13,045,633	
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	13,045,633	0	13,045,633	7,742
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	0	0

COORDINATED CARE CORPORATION

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		57,097,421	
(2)	Company Action Level = 200% of Authorized Control Level	CAL	35,961,746	
(3)	Regulatory Action Level = 150% of Authorized Control Level	RAL	26,971,310	
(4)	Authorized Control Level = 100% of Authorized Control Level	ACL	17,980,873	
(5)	Mandatory Control Level = 70% of Authorized Control Level	MCL	12,586,611	
(6)	Level of Action, if Any	NONE		

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	57,097,421
Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page	17,980,873

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	569,967,437	
(8)	Underwriting Deductions	Page 4, Line 23	561,641,756	
(9)	Combined Ratio	Line (8)/Line (7)	98.539	
(10)	RBC Ratio	Line (1)/Line (4)	317.545	
(11)	Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then “Yes”, otherwise “No”		NO
(12)	Level of Action, if any, including Trend Test		NONE	

Appendix J
Coordinated Care Corporation
Data and Assumption Reliance for 2015 Individual Exchange Premium Development

Data / Assumption	Source
2015 Individual Exchange Enrollment	Charles Kearns, Centene
2015 Individual Exchange Market Share, by county and income bracket	Charles Kearns, Centene
2015 Individual Exchange Attrition, Market Share, and Buy-Ups (by FPL) Assumptions	Charles Kearns, Centene
Aggregate health insurance coverage transition rates, 2011-2014	SOA/Optum ("Cost of the Future Newly Insured under the Affordable Care Act (ACA)")
Pricing and Premium Development Models	Milliman
Basic tables of utilization, cost, claims probability distributions, pricing adjustment factors, and primary care/specialty care utilization distribution	Milliman (Health Cost Guidelines)
Pre-ACA Large Group Claims Cost PMPM	CCIIO (2011 MLR)
Pre-ACA Large Group Actuarial Value	MarketScan (Commercial Claims Database)
Pre-ACA Large Group Unit Costs	MarketScan (Commercial Claims Database) and Billed Charge Discounts (CMS Medicare claims data)
Prospective Morbidity Factors by Health Status, Age, and Gender	US Census Bureau (2009-2011 Current Population Survey), Milliman (Small Group Medical Underwriting Guidelines)
Health insurance transition rate relativities by age, gender, income, and health status	Milliman
Pre-ACA health status distribution by age, income, and insurance coverage	US Census Bureau (2009-2011 Current Population Survey)
Pre-ACA enrollment counts for Individual, Small Group Fully Insured, and Large Group Fully Insured markets	CCIIO (2011 MLR Dataset)
Pre-ACA enrollment counts for Employer Group, Part-Time, Retiree, Medicaid/Other Public, Medicare/Dual, and Uninsured markets	US Census Bureau (2011 American Community Survey)
Distribution of pre-ACA enrollment by age, gender, and income bracket, within each insurance coverage category	US Census Bureau (2011 American Community Survey)
State and Federal High Risk Pool Enrollment	National Conference of State Legislatures ("High Risk Pools for Health Coverage, State and Federal (State Implementation Report)")
2015 Individual Exchange Benefit Designs	Charles Kearns, Centene
Centene pre-ACA enrollment, claims data, and benefit designs	Charles Kearns, Centene
Utilization trends	Milliman
Unit Cost trends	Charles Kearns, Centene
Anticipated Centene Individual Exchange Unit Costs	Centene Reimbursement Targets based on Medicare (CMS Medicare claims data) and Billed Charge Discounts (CMS Medicare claims data)
Administrative Costs, Taxes, and Fees	Charles Kearns, Centene
CCHP Delinquency Numbers	Charles Kearns, Centene
Subcapitated Contracts and Pricing	Charles Kearns, Centene
Value Added Benefits	Charles Kearns, Centene
Smoking Relativity Factors	Charles Kearns, Centene/Milliman
County Rating Areas	Charles Kearns, Centene
Centene Service Areas	Charles Kearns, Centene
Expected Reimbursement by Rating Area and State	Charles Kearns, Centene
OON Inpatient Services Utilization	Charles Kearns, Centene
Utilization Management	Charles Kearns, Centene
3:1 Age Band Factors	HHS
Prescription Drug Assumptions: AWP Discount, Dispensing Fee, Rebates, Retail/Mail Utilization percentages, formularies, and Rx Management Assumptions	US Scripts
Capital, Surplus, and RBC from Annual Statement	Charles Kearns, Centene

Appendix K
Coordinated Care Corporation
Projected Experience with and without Requested Rate Change

	With Requested Rate Change	Without Requested Rate Change
Enrollment Projection	147,869	147,869
Earned Premium		
Next 12 Months	$430.88	$472.26
Next Full Calendar Year	$430.88	$472.26
Anticipated Implementation Date (1)	$430.88	$472.26
Projected Incurred Claims		
Next 12 Months	$320.76	$320.76
Next Full Calendar Year	$320.76	$320.76
Anticipated Loss Ratio		
Next 12 Months	74.4%	67.9%
Next Full Calendar Year	74.4%	67.9%

(1) Anticipated implementation date is 1/1/2015.