Comparación del Balanced Care de Ambetter Planes 73

Beneficios dentro de la red	Balanced Care 4 (2019)	Balanced Care 9 (2019)	Balanced Care 11 (2019)
Visita anual de la persona sana/Evaluaciones/Inmunizaciones/Del bebé sano	**Sin costo**	**Sin costo**	**Sin costo**
Vista pediátrica-Examen de los ojos de rutina (1 visita por año)	**Sin costo**	**Sin costo**	**Sin costo**
Vista pediátrica-Anteojos (monturas, 1 por año)	**Sin costo**	**Sin costo**	**Sin costo**
Vista pediátrica-Lentes (por par)	**Sin costo**	**Sin costo**	**Sin costo**
Programa de recompensas My Health Pays™	**Sin costo**	**Sin costo**	**Sin costo**
Deducible médico (Ind/Fam)	$5,325/$10,650	$3,300/$6,600	$2,625/$5,250
Deducible para medicamentos recetados (Ind/Fam)	Integrado con el deducible médico	Integrado con el deducible médico	Integrado con el deducible médico
Máximo de su propio bolsillo (Ind/Fam)	$5,325/$10,650	$6,300/$12,600	$6,300/$12,600
Visita al consultorio del PCP	$15	$30	$20
Visita al consultorio del especialista	$45	$50	$40
Obtención de imágenes (CT/PET, MRI)	Sin costo después del ded.	$250	40% después del ded.
Radiografías y obtención de imágenes diagnósticas	Sin costo después del ded.	$50	$25 por servicios profesionales y de laboratorio para pacientes ambulatorios; 40% después del ded. para radiografías e imágenes de diagnóstico
Atención médica de urgencia	$75	$50	$75
Sala de emergencia*	Sin costo después del ded.	$250	40% después del ded.
Transporte de emergencia*	Sin costo después del ded.	20% después del ded.	40% después del ded.
Tarifa en instalaciones para pacientes internados	Sin costo después del ded.	20% después del ded.	40% después del ded.
Servicios quirúrgicos y de médicos en hospitales como paciente internado	Sin costo después del ded.	20% después del ded.	40% después del ded.
Tarifas de instituciones para pacientes ambulatorios	Sin costo después del ded.	20% después del ded.	40% después del ded.
Médico cirujano/Servicios quirúrgicos para pacientes ambulatorios	Sin costo después del ded.	20% después del ded.	40% después del ded.
Análisis de laboratorio y diagnóstico	Sin costo después del ded.	$20	$25
Salud mental/del comportamiento y servicios para pacientes ambulatorios para trastorno por abuso de sustancias	$15 para visitas al consultorio; Sin costo después del ded. para todos los demás servicios para pacientes ambulatorios	$30 para visitas al consultorio; Sin costo para todos los demás servicios para pacientes ambulatorios	$20 para visitas al consultorio; 40% después del ded. para todos los demás servicios para pacientes ambulatorios
Servicios de rehabilitación para pacientes ambulatorios (incluye terapia del habla, ocupacional y física)	Sin costo después del ded.	$50	40% después del ded.
Farmacia** (Genéricos / Preferidos / No preferidos / Especializados)	$15 / $50 / Sin costo después del ded. / Sin costo después del ded.	$20 / $40 después del ded. / $70 después del ded. / 20% después del ded.	$20 / $50 / 40% después del ded. / 40% después del ded.

*Los gastos fuera de la red elegibles están cubiertos a nivel dentro de la red. Puede que usted sea responsable por la diferencia entre la cantidad facturada y la cantidad que cubrimos.

**Medicamentos recetados disponibles para pedido por correo con un suministro de 90 días.

Nuestros planes no cubren todos los gastos de atención médica. Los beneficios cubiertos variarán por estado y son solo para proveedores dentro de la red. Para obtener detalles completos sobre beneficios, los miembros deberían revisar su Evidencia de cobertura y Lista de beneficios antes de recibir servicios. Puede haber exclusiones y limitaciones. Ambetter de Arizona Complete Health es una compañía Autorizada de Planes de Salud en el Mercado de seguro médico de Arizona y no discrimina basándose en raza, color, origen nacional, discapacidad, edad, sexo, identidad de género, orientación sexual o estado de salud en la administración del plan, incluso inscripción y determinaciones de beneficios.

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Health Insurance Marketplace

AMB17-AZ-C-00047-2S

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Arizona Complete Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Navajo:	Ni da éí doodago háida bíká anilyeedígíí Ambetter from Arizona Complete Health yína'idílkidgo t'áá ni nizaad k'ehjí níká a'doowoł dóó hazhó'ó bee nił hodoonihgo bee ná haz'ą́ dóó bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koji' hólne' 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Arizona Complete Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-888-926-5057 (TTY/TDD 1-888-926-5180)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Arizona Complete Health , quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Arizona Complete Health ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ (TTY/TDD 1-888-926-5180) 1-888-926-5057.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Arizona Complete Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Arizona Complete Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-926-5057 (TTY/TDD 1-888-926-5180) 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d' Ambetter from Arizona Complete Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-888-926-5057 (TTY/TDD 1-888-926-5180).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Arizona Complete Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-926-5057 (TTY/TDD 1-888-926-5180) an.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Arizona Complete Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Japanese:	Ambetter from Arizona Complete Health について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-888-926-5057 (TTY/TDD 1-888-926-5180) までお電話ください。
Persian:	اگر شما، يا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Arizona Complete Health داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره (TTY/TDD 1-888-926-5057 (TTY/TDD 1-888-926-5180 تماس بگيريد.
Syriac:	ان اتلوخن خورنه ميقورى المساعدة يمصيئون متلفلتن الدوا مشى Ambetter from Arizona Complete Health يمصيوت ميقريوتن المساعدة.. وخني لا شقلخ زوزة منوخن . ان اتلوخون بارا الأني مندي .وان مترجم رقم تلفون (TTY/TDD 1-888-926-5057 (TTY/TDD 1-888-926-5180
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Arizona Complete Health , imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Arizona Complete Health ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Declaración de no discriminación

Ambetter from Arizona Complete Health cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad o sexo. Ambetter from Arizona Complete Health no excluye a las personas ni las trata de manera distinta debido a su raza, color, origen nacional, edad, discapacidad o sexo.

Ambetter from Arizona Complete Health:

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

Si necesita estos servicios, comuníquese con Ambetter from Arizona Complete Health al 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Si cree que Ambetter from Arizona Complete Health no le ha brindado estos servicios o le ha discriminado de otra manera en base a raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja a: Ambetter from Arizona Complete Health Appeals Unit, PO Box 277610, Sacramento, CA 95827, 1-888-926-5057 (TTY/TDD 1-888-926-5180), Fax 1-877-615-7734. Puede presentar una queja en persona o por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter from Arizona Complete Health está disponible para ayudarle. Además puede presentar un reclamo de derechos civiles al U.S. Department of Health and Human Services (Departamento de Salud y Servicio Humanos de EE.UU.), Office for Civil Rights (Oficina de Derechos Civiles) electrónicamente a través del Portal para reclamos de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o teléfono en: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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GENERAL NON-COVERED SERVICES AND EXCLUSIONS

In addition to the Limitations and Exclusions described in the section titled *Description of Benefits* the following services are not covered or are limited in benefit application unless expressly stated in the Evidence of Coverage:

Abortions: Elective abortions are not covered under this Health Plan. Abortions which are determined to be *medically necessary* to save the life of the woman, or due to rape, incest, life-endangerment, or necessary to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion are covered.

Altered Gender Characteristics: Any procedure or treatment designed to alter physical characteristics of the *member* from the *member's* biologically determined gender to those of another gender, regardless of any diagnosis of gender role disorientation or psychosexual orientation. Treatment for hermaphroditism and any studies or treatment related to gender transformation or hermaphroditism.

Alternative Therapies: Acupuncture, acupressure, hypnotherapy, biofeedback (for reasons other than pain management, and for pain management related to Mental Health and Substance Abuse) behavior training, educational, recreational, art, dance, sex, sleep or music therapy, and other forms of holistic treatment or alternative therapies, unless otherwise specifically stated as a covered benefit in the Evidence of Coverage.

Applied Behavioral Health Therapy (ABA): ABA is only covered for the treatment of Autism Spectrum Disorder. The following services are not covered: Sensory Integration; LOVAAS Therapy and; Music Therapy.

Bariatric Surgery: We provides benefits for *medically necessary* and *not experimental, unproved or investigational.* These *covered services* must be *authorized* by *us* in accordance with *our* evidence based criteria for this intervention contained in *our* National Medical Policy on Bariatric Surgery which can be found at www.ambetterhealthnet.com under the medical policies link. Benefits are not payable for expenses excluded in the EOC or for the following: Jejunoileal bypass (jejuno-colic bypass); Loop Gastric Bypass (i.e., "Mini-Gastric Bypass"); Open sleeve gastrectomy; Gastric balloon; Gastric wrapping; Gastric Imbrication; Gastric pacing; Fobi pouch.

Benefits or Services (Non-Covered): Services, supplies, treatments or accommodations which: Are not *medically necessary* except as specifically described in the Evidence of Coverage; Are not specifically listed as a Covered Service in the Evidence of Coverage, whether or not such services are *medically necessary;* Are incident or related to a non-Covered Service; Are not considered generally accepted health care practices; Are considered *cosmetic* as determined by *us,* unless specifically listed as a *coverage* in the Evidence of Coverage; Are provided prior to the *effective date* of *coverage* hereunder, or after the termination date of *coverage* hereunder; Are provided under Medicare or any other government program except *Medicaid*; The person is not required to pay, or for which no charge is made.

Blood Products: Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures. Salvage and storage of umbilical cord and/or after birth are not covered.

Braces: *Over-the-counter* braces; Prophylactic braces; Braces used primarily for sports activities.

Breast Implants, Prostheses: Breast implants, including replacement, except when *medically necessary*, and related to a *medically necessary* mastectomy. Removal of breast implants, except when *medically necessary.*

Chiropractic Care: Any services provided by a *non- network chiropractor* regardless of whether the services were obtained within or outside of the Health Plan's Service Area; Any services, including consultations (except for the initial evaluation visit), that are not *authorized* by the designated Chiropractic *provider* as shown in the Schedule of Benefits; Any treatments or services, including x-rays, determined to not be related to neuromusculoskeletal disorders as defined by the designated Chiropractic *provider* as shown in the Schedule of Benefits; Services which are not provided in a *network chiropractor's* office; Services or expenses which exceed the *member's* maximum allowable benefit. Services which exceed the *member's* maximum allowable benefit will be the *member's* financial responsibility; Expenses incurred for any services provided before *coverage* begins or after *coverage* ends according to the terms of this *Policy*; Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic testing, except that which occurs during the normal course of covered chiropractic treatment; Prescription medications. Vitamins, nutritional supplements or related products, even if they are prescribed or recommended by a *network chiropractor,* Services provided on an *inpatient* basis; Rental or purchase of Durable Medical Equipment, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances or equipment as ordered by *network chiropractor* even if their use or installation is for the purpose of providing therapy or easy access; Expenses resulting from a missed appointment which the *member* failed to cancel; Treatment primarily for purposes of obesity or weight control; Vocational rehabilitation and long-term rehabilitation; Hypnotherapy, acupuncture, behavior training, sleep therapy, massage or biofeedback; Radiological procedures performed on equipment not certified, registered or licensed by the State of Arizona, or the appropriate licensing agency, and/or radiological procedures that, when reviewed by the designated Chiropractic *provider* as shown in the Schedule of Benefits, are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment; Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as *experimental, unproved or investigational* and/or as being in the research stage; Services and/or treatments that are not documented as *medically necessary* services; All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids; Adjunctive therapy not associated with spinal, muscle or joint manipulation; Manipulation under anesthesia.

Circumcision: Non-*medically necessary* circumcisions after the *newborn period,* including cases of premature birth.

Communication and Accessibility Services: *Provider* expenses for interpretation, translation, accessibility or special accommodations.

Complications of Non-Covered Expenses: Complications of an ineligible or excluded condition, procedure or service (non- *covered expenses*), including services received without *authorization.*

Cosmetic Surgery or Reconstructive Surgery: *Cosmetic* or Reconstructive surgery, which in the opinion of *us* is, performed to alter an abnormal or normal structure solely to render it more esthetically pleasing where no significant anatomical functional impairment exists. The following are examples of non- *covered services*: Rhinoplasty and associated surgery; Rhytidectomy or rhytidoplasty; Breast augmentation/implantation; Blepharoplasty without visual impairment; Breast reduction which is not *medically necessary,* as determined by *us*; Otoplasty; Skin lesions without functional impairment, suspicion of malignancy or located in area of high friction; Keloids; Procedures utilizing an implant which does not alter physiologic function; Treatment or surgery for sagging or extra skin; Liposuction; Mon-*medically necessary* removal or replacement of breast implants, as determined by *us.*

Cosmetic or Reconstructive surgery performed, in our opinion, to correct injuries that are the result of *accidental injury* is a Covered Service. In addition, this exclusion does not apply to breast reconstruction incidental to a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a Covered *dependent* is limited to the *medically necessary* care and treatment of medically diagnosed congenital *defect* and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the **newborn period** if *medically necessary* and medical criteria are met.

Counseling Services: Unless otherwise specifically stated as a covered benefit in the Evidence of Coverage; Counseling for conditions that DSM identifies as relational problems (e.g. couples counseling, family counseling for relation problems); Counseling for Conditions that the DSM identifies as additional conditions that may be a focus of clinical attention (e.g. educational, social, occupational, religious, or other maladjustments); Sensitivity or stress-management training and self-help training

Court or Police Ordered Services: Examinations, reports or appearances in connection with legal proceedings, including child custody, competency issues, parole and/or probation and other court ordered related issues. Services, supplies or accommodations pursuant to a court police order, whether or not *injury* or sickness is involved.

Custodial Care: Any service, supply, care or treatment that we determine to be incurred for rest, domiciliary, convalescent or *custodial care.* Examples of non- *covered services* include: Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications; Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse; Non-covered *custodial care* Services no matter who provides, prescribes, recommends or performs those services; Services of a person who resides in the *member's* home, or a person who qualifies as a *family member,* The fact that certain *covered services* are provided while the *member* is receiving *custodial care* does not require *us* to cover *custodial care.*

Dental Services: The *medical* portion of *your health plan* covers only those dental services specifically stated in the section titled *Description of Benefits.* All other dental services are excluded.

Devices: Bionic and hydraulic devices, except when otherwise specifically described in the Evidence of Coverage.

Diabetic Supplies, Equipment and Devices: Diabetic supplies are covered when *medically necessary.* The following are specific requirements for *coverage:* Diabetic supplies must have a written prescription from a *provider,* when *medically necessary*; Refills are covered only when *authorized* by a *provider,* when *medically necessary*; *Covered Services* must be obtained from a *provider* unless otherwise *authorized* by *us*; Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent *members* when necessary for medical management as determined by *us* in consultation with *your physician.* Blood glucose monitors require a prescription from a *physician* and must be obtained at a Pharmacy; Plan approved blood glucose monitors for the legally blind are covered when *medically necessary* and the *member* has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a Pharmacy.

Dietary Food or Nutritional Supplements: Non- *covered services* include the following: Dietary food, nutritional supplements, special formulas, and special diets provided on an *outpatient*, ambulatory or home setting; Food supplements and formulas, including enteral nutrition formula, provided in an *outpatient*, ambulatory or home setting except as otherwise stated in the Evidence of Coverage or in the *Schedule of Benefits*; Nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated in the Evidence of Coverage or in the Schedule of Benefits. This includes those nutritional supplements given between meals to increase daily protein and caloric intake; Services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services.*

Disability Certifications: Disability Certifications if not required by *us.*

Durable Medical Equipment: *Durable Medical Equipment* that fails to meet the criteria as established by *us.* Examples of Non-*covered services* include, but are not limited to the following: Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment; Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been *authorized* by *us*; More than one *DME* device designed to provide essentially the same function; Foot *orthotics*, except when attached to a permanent brace or when prescribed for the treatment of diabetes (refer to exclusion entitled foot *orthotics*) (This exclusion does not apply to *coverage* for special shoes and inserts for certain patients with diabetes. Please refer to your diabetic benefits for further specification); Deluxe, electric, model upgrades, *specialized or custom durable medical equipment, prosthetics or orthotics* or

other non-standard equipment; Repair or replacement of deluxe, electric, *specialized or custom durable medical equipment,* model upgrades, and portable equipment for travel; Transcutaneous Electrical Nerve Stimulation (TENS) units; Scooters and other power operated vehicles; Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring, Model upgrades and duplicates, except as specifically listed as being covered in the Evidence of Coverage; Repair, replacement or routine *maintenance* of equipment or parts due to misuse or abuse; Over-the counter braces and other *DME* devices, except as specifically listed as being covered in the Evidence of Coverage; Prophylactic braces and other *DME* devices, except as specifically listed as being covered in the Evidence of Coverage; Braces used primarily for sports activities; ThAIRapy® vests, except when our medical criteria is met; Communication devices (speech generating devices) and/or training to *use* such devices; and Pulse oximeters.

Emergency Services: Use of *emergency facilities* for non-*emergency* purposes. *Routine Care,* follow-up care or continuing care provided in an Emergency Facility, unless such services were *authorized* by the *Primary Care Physician* or *us.*

Exercise Programs: Exercise programs, yoga, hiking, rock climbing and any other types of sports activity, equipment, clothing or devices.

Ex-Member (Services for): Benefits and services provided to an ex-*member* after termination of the ex-*member.*

Experimental, Investigational Procedures, Devices, Equipment and Medications: *Experimental, unproved or investigational* medical, surgical or other *experimental* health care procedures, services, supplies, medications, devices, equipment or substances. *Experimental, unproved or investigational* procedures, services or supplies are those which, in *our* judgment: Are in a testing stage or in field trials on animals or humans; Do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed; Are not in accordance with generally accepted standards of medical practice; Have not yet been shown to be consistently effective for the diagnosis or treatment of the *member's* condition; Are medications or substances being used for other than FDA approved indications; and/or; are medications labeled "Caution, Limited by Federal Law to Investigational Use."

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

Family Member (Services Provided by) and Member Self-Treatment: Professional services, supplies or *provider referrals* received from or rendered by a non-Ambetter contracted immediate *family member* (spouse, domestic partner, child, parent, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by a non-Ambetter contracted immediate *family member* of the *member; Member* self-treatment including, but not limited to self-prescribed medications and medical self-ordered services.

Foot Orthotics: See exclusion titled *orthotics.*

Fraudulent Services: Services or supplies that are obtained by a *member* or non-*member* by, through or otherwise due to fraud.

Gastric Stapling/Gastroplasty: Open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding.

Genetic Testing, Amniocentesis: Services or supplies in connection with genetic testing, except those which are **medically necessary**, as determined by *us.* Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purpose of determining the gender of a fetus.

Governmental Hospital Services: Services provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces Facilities for non-service related medical conditions. Care for conditions that federal, state, or local law requires treatment in a public *facility.*

Growth Hormone: Human Growth Hormone except for children or adolescents who have one of the following conditions: Documented growth hormone deficiency causing slow growth; Documented growth hormone deficiency causing infantile hypoglycemia; Short stature and slow growth due to: 1) Turner syndrome, 2) Prader-Willi syndrome, 3) Chronic renal insufficiency prior to transplantation, 4) Central nervous system tumor treated with radiation; Documented growth hormone deficiency due to a hypothalmic or pituitary condition.

Habilitative Services: *Habilitative services* when medical documentation does not support the *medical necessity* because of the *member's* inability to progress toward the treatment plan goals or when a *member* has already met the treatment plan goals.

Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, cheerleaders. Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, *custodial care,* or education services of any kind, including, but not limited to, vocational training.

Hair Analysis, Treatment and Replacement: Testing using a patient's hair except to detect lead or arsenic poisoning; hair growth creams and medications; implants; scalp reductions.

Heavy Metal Screening and Mineral Studies: Heavy metal screenings and mineral studies. Screening for lead poisoning is covered when directed through the *Primary Care Physician.*

Home Maternity Services: Services or supplies for maternity deliveries at home.

Household and Automobile Equipment and Fixtures: Purchase or rental of household equipment or fixtures having customary purposes that are not medical. Examples of Non- *covered services* include: exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, hygienic equipment or other household fixtures.

Immunizations: Immunizations that are not *medically necessary* or medically indicated.

Impotence (Treatment of): All services, procedures, devices associated with impotence or erectile dysfunction regardless of associated medical, emotional or psychological conditions, causes or origins unless otherwise specifically stated in the Evidence of Coverage.

Ineligible Status: Services or supplies provided before the *effective date* of *coverage* not cover. Services or supplies provided after midnight on the *effective date* of cancellation of coverage are not covered, except as specified in the "Extension of Benefits."

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

Infertility Services: Services associated with infertility are limited to diagnostic service rendered for infertility evaluation. The following services and treatments are not covered: Artificial insemination services; Reversal of voluntary sterilization procedures; In vitro fertilization; Embryo or ovum transfer; Zygote transfers; Gamete transfers; GIFT procedure; Cost of donor sperm or sperm banking; Foams and condoms; Medications used to treat infertility; Services, procedures, devices and medications associated with impotence and/or erectile dysfunction unless otherwise specifically stated in the Evidence of Coverage or in the *Schedule of Benefits.*

Institutional Requirements: Expenses for services provided solely to satisfy institutional requirements.

Intoxicated or Impaired: Services or supplies for any *illness, injury* or condition caused in whole or in part by or related to the *member's* use of a motor vehicle when tests show the *member* had a blood alcohol level in excess of that permitted to legally operate a motor vehicle under the laws of the state in which the *accident* occurred, except in cases in which we determine the *illness, injury,* or condition was a result of a substance abuse disorder.

Late Fees, Collection Expenses, Court Costs, Attorney Fees: Any late fees or collection expenses that a *member* incurs incidental to the payment of services received from *providers,* except as may be required by state or federal law. Court costs and attorney fees. Costs due to failure of the *member* to disclose insurance information at the time of treatment.

License (Not Within the Scope of): Services beyond the scope of a *provider's* license.

Lost Wages and Compensation for Time: Lost wages for any reason. Compensation for time spent seeking services or *coverage* for services.

Medical Supplies: Consumable or disposable medical supplies, except as specifically provided in the Evidence of Coverage. Examples of non- *covered services* include bandages, gauze, alcohol swabs and dressings, foot coverings, leotards, elastic knee and elbow Supports not provided in the *Primary Care Physician's* office, except as required by state or Federal law. Medical supplies necessary to operate a non-covered *prosthetic device* or item of *DME.*

Mental Health: *Covered Services* do not include the following: Treatment for chronic or organic conditions, including Alzheimer's, dementia or delirium. Delirium will not be excluded when reported as a symptom of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. This exclusion does not apply to the initial assessment for diagnosis of the condition; Ongoing treatment for mental disorders that are long-term or chronic in nature for which there is little or no reasonable expectation for improvement, unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. These disorders include mental retardation, and organic brain disease. This exclusion does not apply to the initial assessment for diagnosis of the condition; Mental Health treatment of erectile dysfunction and sexual dysfunction; Counseling, testing, evaluation, treatment or other services in connection with the following are not covered unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10: learning disorders and/or disabilities, non-medical ancillary services including but not limited to vocational rehabilitation or therapeutic approaches that are not well supported in evidence based studies, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays and mental retardation. This exclusion does not apply to the initial assessment for diagnosis of the condition; Psychological testing or evaluation specifically for ability, aptitude, intelligence, interest or competency; Psychiatric evaluation, therapy, counseling or other services in connection with the following: child custody, parole and/or probation, and other court ordered related issues; Marriage counseling unless otherwise specifically stated as a Covered Service in the *Schedule of Benefits*; Expenses incurred for missed appointments or appointments not canceled 24 hours in advance; and Wilderness programs and/or therapeutic boarding schools that are not licensed as *Residential Treatment Centers.*

Missed Appointments, Telephone and Other Expenses: The following are not covered: Expenses made to *member* by a *provider* for not keeping or the late cancellation of appointments; Charges by *members* or *providers* for telephone consultations, except for Services provided through telemedicine if such services are otherwise covered when provided in person, and clerical services for completion of special reports or forms of any type, including but not limited to Disability certifications are not covered; Charges by *members* or *providers* for copies of medical records supplied by a health care *provider* to *member.*

Telemedicine services are covered as shown under the "Description of Benefits" section in this EOC.

Non-Licensed Providers: Treatment or services rendered by non-licensed health care *providers* and treatment or services outside the scope of a license of a licensed health care *provider* or services for which the *provider* of services is not required to be licensed. This includes treatment or services from a non-licensed *provider* under the supervision of a licensed *physician*, except for services related to behavioral health treatment for Pervasive Developmental Disorder or Autism.

Non-Medically Necessary Services: Services, supplies, treatments or accommodations which are not *medically necessary* except as specifically described in the Evidence of Coverage.

Non-Participating Pharmacy: Benefits and services from *non-network pharmacies* (any Pharmacy that has not contracted with Ambetter from Arizona Complete Health to provide prescription medications to *members* covered under this *Policy*) are not

covered. This can include specific stores within a chain of stores.

Non-Participating Provider (Services Rendered by): Benefits and services from *non-network providers*, except in the case of a medical *emergency.*

Nutritionists: Services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services.*

Obesity: Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity or as a Preventive Care Services.

Orthotics: Repair, maintenance and repairs due to misuse and/or abuse; *Over-the-counter* items, except as specifically listed as being covered in the Evidence of Coverage; Prophylactic braces; Braces used primarily for sports activities; Foot *orthotics,* except when attached to a permanent brace or when prescribed for the treatment of diabetes.

Out-of-Service Area Services: Unauthorized services received outside of Ambetter's Service Area, except for *emergency services* as defined in this *Policy*. Examples of non- *covered services* include the following: Services or treatments which could have been provided by a *network provider* within the Service Area; Services which were furnished after the *member's* condition would have permitted the *member* to return to the Service Area for continued care; Services connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery. This does not apply to *emergency services* as defined in this *Policy*; and Treatment in progress by a *network provider.*

Over-the-Counter Items and Medications: *Over-the-counter* items and medications, except as specifically listed as a covered benefit in the Evidence of Coverage or in the *Schedule of Benefits.* Exceptions covered in the Evidence of Coverage include covered Preventive Medications, and medications as indicated under the provisions titled Diabetic Supplies, Equipment and Devices. For purposes of this *Policy, over-the-counter* is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.

Oxygen: Oxygen when services are outside of the Service Area and non-*Emergent* or Urgent, or when used for convenience when traveling within or outside of the Service Area.

Paternity Testing: Diagnostic testing to establish paternity of a child.

Penile Implants: Any costs or expenses for or related to penile implants.

Personal Comfort Items: Personal comfort or convenience items, including services such as guest meals and accommodations, telephone expenses, non-*Qualified Travel Expenditures*, take-home supplies, barber or beauty services, radio, television and private rooms unless the private room is *medically necessary.*

Physical and Psychiatric Exams: Physical health examinations in connection with the following: Obtaining or maintaining employment; Obtaining or maintaining school or camp attendance; At the request of a third party; Sports participation whether or not school related; Obtaining or maintaining insurance qualification.

Psychiatric or psychological examinations, testing and/or other services in connection with: Obtaining or maintaining employment; Obtaining or maintaining insurance relating to employment or insurance; Obtaining or maintaining any type of license; Medical research; Competency issues.

Physical Conditioning: Health conditioning programs and other types of physical fitness training. Exercise equipment, clothing, performance enhancing drugs, nutritional supplements and other regimes.

Prescription Medications: Refer to the *outpatient prescription drug* benefit for the restrictions and limitations that apply.

Private Duty Nursing: *Private Duty Nursing* and private rooms except when determined to be *medically necessary* as determined by us. *Private Duty Nursing* does not include non-skilled care, *custodial care,* or respite care.

Public or Private School: Charges by any public or private school or halfway house, or by their employees.

Radial Keratotomy, Lasik: Radial Keratotomy, LASIK surgery and other refractive eye surgery.

Reconstructive Surgery: Reconstructive surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function expected. This exclusion does not apply to breast reconstruction following a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a Covered *dependent* is limited to the *medically necessary* care and treatment of medically diagnosed *congenital defects* and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the *newborn period* if *medically necessary* and medical criteria are met.

Rehabilitation and Habilitation Services: Rehabilitation and habilitation services, *maintenance* and/or non- *acute* therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally

predictable period of time are not covered. Rehabilitative and habilitation services related to 1) developmental delay, 2) maintaining physical condition, 3) *maintenance* therapy for a Chronic Condition are not *covered services*. However, Rehabilitation and Habilitation therapy for physical impairments in *members* with Autism Spectrum Disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation and habilitation therapy are met.

Residential Treatment Center: Residential treatment that is not medically necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for *custodial care*; for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

Reversal of voluntary sterilization procedures: Expenses for services to reverse voluntary sterilization.

Riots, War, Misdemeanor, Felony: *Illness or injury* sustained by a *member* caused by or arising out of riots, war (whether declared or undeclared), insurrection, rebellion, armed invasion or aggression. *Illness* or *injury* sustained by a *member* while in the act of committing a misdemeanor, or felony, or while engaging in an illegal occupation, unless the condition was an *injury* resulting from an act of domestic violence or an *injury* resulting from a medical condition, mental health condition, or substance abuse disorder.

Routine Foot Care: Routine foot care. Examples of non- *covered services* include trimming of corns, calluses and nails, and treatment of flat feet.

Sexual Dysfunction: Behavioral treatment for sexual dysfunction and sexual function disorders regardless if cause of dysfunction is due to physical or psychological reasons.

Shipping, Handling, Interest Expenses: All shipping, delivery, handling or postage expenses except as incidentally provided without a separate charge, in connection with *covered services* or supplies. Interest or finance charges except as specifically required by law.

Skin Titration Testing: Skin titration (wrinkle method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine autoinjection, provocative and neutralization testing for allergies.

Speech and Language Services: Speech therapy services, *maintenance* and/or non- *acute* therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by *us* in consultation with the treating *provider.* Any combination of therapies (including speech and language therapies) that exceed the maximum allowable benefits as described in the *Schedule of Benefits*. Communication devices (speech generating devices). Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or *maintenance* therapy for a Chronic Condition are not covered. However, Rehabilitation and habilitation therapy for physical impairments in *members* with autism spectrum disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation and habilitation therapy are met.

Substance Abuse Services: *Covered Services* do not include: Court ordered testing and/or evaluation; *Referral* for non- *medically necessary* services such as vocational programs or employment counseling; Expenses related to a stay at a sober living *facility.* Sober living *facilities* are *custodial care* institutions, which are not a covered benefit.

Temporomandibular Joint Disorder (Treatment of): *Covered Sevices* under the *medical* portion of your *health plan* do not include: Dental prosthesis or any treatment on or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental *specialist;* Treatment of pain or infection due to a dental cause, surgical correction of malocclusion prognathic surgery, orthodontia treatment, including *hospital* and related costs resulting from these services when determined to relate to malocclusion; Services related to injuries caused by or arising out of the act of chewing; and Treatment of obstructive sleep apnea.

Thermography: Thermography or thermograms related expenses.

Transplant Services: *Covered Services* for transplants do not include: Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a *member* covered under this health Plan; Transplants that are considered *experimental, unproved* or *investigational;* Non-human or artificial organs, and the related implantation services; Donor searches; VADs when used as an artificial heart

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

Transportation Services: Transportation of a *member* to or from any location for treatment or consultation, except for ambulance services associated with a *medically necessary emergency* condition and travel services associated with organ transplant benefits. Travel and lodging are not covered if the *member* is a donor.

Travel Expenses: Travel and room and board, even if prescribed by a physician for the purpose of obtaining *covered services.* This does not apply to *Qualified Travel Expenditures.*

Urgent Care Services: Use of *Urgent Care Facilities* for non-*urgent care* purposes. *Routine Care,* follow-up or continuing care provided in an *Urgent Care Facility.*

Vision Services: Vision services are covered as specified in the Vision Services section under the Description of Benefits of this *Policy* and the *Schedule of Benefits.*

Pediatric Vision Services and supplies when *medically necessary* are covered for children up to the last day of the month he or she turns age 19, as described in the Schedule of Benefits under Pediatric Vision Services.

The following Adult Vision Services are not covered: Eyeglasses and contact lenses, and the vision examination for prescribing and fitting of same, except as specifically listed as a covered benefit in the Evidence of Coverage; Eye examinations required by an employer as a condition of employment; Services or materials provided as a result of any workers' compensation law, or required by any government agency; Radial keratotomy and other refractive eye surgery; Orthoptics, vision training, or subnormal vision aids.

If you have elected additional Adult Vision Benefits, please refer to the Vision Benefit Rider for a description of services and the limitations that apply.

Vitamin B-12 Injections: Vitamin B-12 injections are not covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed.

Vocational Programs/Employment Counseling: Vocational programs and counseling for employment, including counseling during mental or substance abuse rehabilitation.

Work-Related Injuries: Expenses in connection with a work-related *injury* or sickness for which *coverage* is provided under any state or federal Worker's Compensation, employer's liability or occupational disease law.