



FROM



**silversummit
healthplan**

2019 Evidence of Coverage



Ambetter.SilverSummitHealthplan.com

Ambetter from SilverSummit Healthplan, Inc.

Home Office: 2500 N. Buffalo Drive, Suite 250, Las Vegas, NV 89128

Major Medical Expense Insurance Policy

In this *policy*, the terms "*you*", "*your*", or "*yours*" will refer to the *member* or any *dependents enrolled in this contract*. The terms "*we*," "*our*," or "*us*" will refer to SilverSummit Healthplan, Inc.

AGREEMENT AND CONSIDERATION

In consideration of *your* application and the timely payment of premiums, *we* will provide benefits to *you*, the *member*, for *covered services* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations, and exclusions.

GUARANTEED RENEWABLE

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

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this Contract in the following events: (1) non-payment of premium; (2) a Member moves outside the Service Area; (3) a Member fails to pay any Deductible or Copayment Amount owed to us and not the Provider of services; (4) a Member is found to be in material breach of this Contract; or (5) a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

Annually, *we* may change the rate table used for this *policy* 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 60 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 *policy* or a change in a *member's* health. While this *policy* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and decide not to renew all policies 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.

This *policy* contains *prior authorization* requirements. *You* may be required to obtain a referral from a *primary care physician* in order to receive 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 POLICY

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

Silver Summit Healthplan, Inc.

A handwritten signature in black ink, appearing to read 'Garrett Leaf', with a stylized, flowing script.

Garrett Leaf
CEO and Plan President

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Introduction

Welcome to Ambetter from SilverSummit Healthplan! We have prepared this *policy* to help explain *your* coverage. Please refer to this *policy* whenever *you* require medical services.

It describes:

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

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

This *policy* should be read in its entirety. Because many of the provisions are interrelated, *you* should read this entire *policy* to get a full understanding of *your* coverage. Many words used in this *policy* have special meanings when used in a healthcare setting: these words are *italicized* and are defined for *you* in the Definitions section. This *policy* also contains exclusions, so please be sure to read this entire *policy* carefully.

How to Contact Us

SilverSummit Healthplan
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. PST

Member Services **1-866-263-8134**

TDD/TTY line **1-855-868-4945**

Fax **1-855-252-0568**

Emergency **911**

24/7 Nurse Advice Line **1-866-263-8134**

Interpreter Services

Ambetter from SilverSummit Healthplan has a free service to help *our members* who speak languages other than English. This service allows *you* and *your physician* to talk about *your* medical or behavioral health concerns in a way that is most comfortable for you.

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

To arrange for interpretation services, please call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

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, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care physician* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or *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. See *your* medical records.
12. Be kept informed of *covered* and *non-covered services*, program changes, how to access services, *primary care physician* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 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.
13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, gender, sex, sexual orientation, disability, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.

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

You have the responsibility to:

1. Read this entire *policy*.
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* ID 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* 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 the entity with which *you* enrolled.
15. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts, or cost sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 days from the date of the event.

Your Provider Directory

A listing of *network providers* is available online at Ambetter.SilverSummitHealthplan.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 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 list of providers near *you* at no charge by calling Member Services at 1-866-263-8134 (TDD/TTY: 1-855-868-4945). In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. We can help *you* pick a *primary care* provider (PCP). We can make *your* choice of *primary care* provider effective on the next business day.

Call the *primary care physician's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-866-263-8134 (TDD/TTY: 1-855-868-4945). We will help *you* make the appointment.

Your Member ID Card

When *you* enroll, we will mail *you* a Member ID card after we receive *your* completed enrollment materials, which include receipt of *your* initial premium payment. 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 *policy*.

The ID card will show *your* name, member ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-866-263-8134 (TDD/TTY: 1-855-868-4945). We will send *you* another card.

Our Website

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

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

Quality Improvement

We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve

your health and help *you* with any *illness* or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards 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 *policy*, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy*:

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*.

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

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

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

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

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

Applied behavior analysis or **ABA** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Assistant behavior analyst means a person who holds current certification as a Board Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, and is licensed as an assistant behavior analyst by the Aging and Disability Services Division.

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

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

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

Autism spectrum disorder means a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the edition of the Manual that was in effect at the time the condition was diagnosed or determined.

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.

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

Behavior analyst means a person who holds current certification as a Board Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, and is licensed as a behavior analyst by the Division.

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

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

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

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *medically necessary 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*.

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from *pregnancy*, but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy*. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *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*.

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury, illness, or congenital anomaly*.

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

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

Cost sharing reductions lower the amount you have to pay in Deductibles, Copayments and Coinsurance. To qualify for Cost Sharing Reductions, an eligible individual must enroll in a silver level plan through the Marketplace or be a member of a federally recognized American Indian tribe and/or an Alaskan Native enrolled in a QHP through the Marketplace.

Covered service or covered service expenses means healthcare services, supplies, or treatment as described in this *policy* 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 *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

Covered person means *you, your lawful spouse or domestic partner, and each eligible child*:

1. Named in the application; or
2. Whom we agree in writing to add as a *covered person*.

Custodial care is treatment designed to assist a *covered person* 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.

Such treatment is custodial regardless of who orders, prescribes, or provides the treatment.

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

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

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

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

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* or *domestic partner* or an *eligible child*.

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

Domestic Partners means persons who:

1. Have registered a valid domestic partnership pursuant to NRS 122A.100 or have a recognized domestic partnership pursuant to NRS 122A.500;
2. Have not terminated that domestic partnership pursuant to NRS 122A.300; and
3. Domestic partnership means the social contract between two persons that is described in NRS 122A.100 or is recognized pursuant to NRS 122A.500.

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 date a *member* becomes covered under this *policy* 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;
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
5. A stepchild.

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

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

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

Please note: *You* may be billed for the difference between the amount paid and the *non-network provider's* charge.

- b. When a *covered service* is received from a *non-network provider* as *approved* or *authorized* by *us* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with *us*, the *eligible service expense* is the greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. *You* may be billed for the difference between the amount paid and the *provider's* charge.
- c. When a *covered service* is received from a *non-network provider* because the service or supply is not available from any *network provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with *us*, the *eligible service expense* is the greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. *You* may be billed for the difference between the amount paid and the *provider's* charge.

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* 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 *policy* are not subject to lifetime or annual dollar maximums. Certain non-*essential health benefits*, however, are subject to either a lifetime or annual dollar maximum.

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 *policy*.

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

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 *policy*.

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 services, supplies, or treatment for medical, behavioral health, or *substance abuse* 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.

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

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;
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 54.9802-1(d)) that includes the individual;
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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, SilverSummit Healthplan, Inc. pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

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

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

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

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

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

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

Medical 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 standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental* or *investigational*;
6. 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 health disorder means a behavioral, emotional, or cognitive disorder that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the most recent edition of the International Classification of Diseases (ICD-10).

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

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

Outpatient services include facility, ancillary, and professional charges when given as an outpatient at a *hospital*, alternative care facility, retail health clinic, or other *provider* as determined by the plan. These facilities may include a *non-hospital* site providing diagnostic and therapy services, *surgery*, or

rehabilitation, or other *provider facility* as determined by us. Professional charges only include services billed by a *physician* or other professional.

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

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

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*.

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

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

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 service expenses*.

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

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

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

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

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

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

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.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This includes *acute rehabilitation, sub-acute rehabilitation, or intensive day rehabilitation*, and it includes *rehabilitation therapy* and 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 licensed practitioner means, but is not limited to, a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

Rescission of a policy means a 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.

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

Service Area means a geographical area, made up of counties, where *we* have been authorized by the State of Nevada 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 is a physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance abuse disorders* are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the most recent edition of the International Classification of Diseases (ICD-10).

Surgery or **surgical procedure** means:

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

Surveillance tests for ovarian cancer means annual screening using:

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

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth services includes synchronous interactions and asynchronous store and forward transfers

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

Terminally ill means a *physician* has given a prognosis that a *member* has 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 *policy* 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, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

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

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

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

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

Dependent Member Coverage

Dependent Member Eligibility

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

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

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

Effective Date for Initial Dependent Members

The effective date for your initial dependent members will be the same date as your initial coverage date. Only dependent members included in the application for this 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.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Health Insurance 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 within the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, the *policy* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice from the entity that you have enrolled (either the Marketplace or *us*) 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 for *loss* due to *injury* and *illness* including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

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

As used in this provision, "*placement*" 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* are enrolled in an off-marketplace policy and apply in writing to add a *dependent member* and *you* pay the required premiums, *we* will send *you* written confirmation of the added *dependent member's* effective date of coverage and ID cards for the added *dependent*.

Ongoing Eligibility

For All Members

A *member's* eligibility for coverage under this *policy* 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 *policy*;
2. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
3. The date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this contract, or any later date stated in your request;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this contract or the date that *we* have not received timely premium payments in accordance with the terms of this contract;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact or
6. The date of a *member's* death.

For Dependent Members

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

All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*. If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact 1-866-263-8134 (TDD/TTY: 1-855-868-4945).

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

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

Open Enrollment

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

Special and Limited Enrollment

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

1. A *qualified individual* or *dependent* loses minimum essential coverage;
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, or placement for adoption of a *member* or their *spouse*;
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 policy in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change 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.

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

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

Non-Silver State Health Insurance Exchange /Marketplace Plan Enrollment

Individuals may enroll in a non-Silver State Health Insurance Exchange/Marketplace plan (an off-exchange/offMarketplace plan) at any time during the calendar year. Coverage for an off-exchange/off-marketplace plan is subject to a waiting period of 90 days, pursuant to NRS 687B.480. Waiting periods for enrollment are defined as beginning on the date the application for coverage was received and will not exceed 90 days. Coverage shall become effective of the first day of the month immediately succeeding the month in which the waiting period expires and is not retroactive to the date on which the application for coverage was received

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*, although an extension may be provided during the annual Open Enrollment period.

Grace Period

When a *member* is receiving a premium subsidy:

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

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

Third Party Payment of Premiums

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

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

Misstatement of Tobacco Use

The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *policy*, *we* have the right to rerate the *policy* 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.

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 *you* or *your dependent member*:

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

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

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

After *prior authorization* has been requested and all required or applicable documentation has been submitted, *we* will notify *you* and *your provider* if the request has been *approved* as follows:

1. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or *emergency* admission.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For urgent *pre-service*, within 72 hours from date of receipt of request.
4. For non-urgent *pre-service* requests within 5 days, but no longer than 15 days, of receipt of the request.
5. For post-service requests, within 30 calendar days of receipt of the request.

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.

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

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

Prior Authorization Does Not Guarantee Benefits

Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy*.

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 has already paid or 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*.

Services from Non-Network Providers

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

Hospital Based Providers

When receiving care at an Ambetter participating *hospital* it is possible that some *hospital-based providers* (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating *providers*. These *providers* may bill *you* for the difference between Ambetter's allowed amount and the *providers* billed charge – this is known as “*balance billing*”. *We* encourage *you* to inquire about the *providers* who will be treating *you* before *you* begin *your* treatment, so *you* can understand their participation status with Ambetter.

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

Cost Sharing Features

Cost Sharing Features

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

Copayments

Members may be required to pay *copayments* at the time of services as shown in the *Schedule of Benefits*. Payment of a *copayment* does not exclude the possibility of an additional billing if the service is determined to be a *non-covered service*. *Copayments* do not apply toward the *deductible amount*, but do apply toward meeting the *maximum out-of-pocket amount*.

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 amount* does not include any *copayment amount* or *coinsurance* amount. Not all *covered service expenses* are subject to the *deductible amount*. See your *Schedule of Benefits* for more details.

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*; 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 *non-network provider* bills you for the services or supplies. Any amount you are obligated to pay to the *non-network provider* in excess of the *eligible service expense* will not apply to your *deductible amount* or *maximum out-of-pocket*.

Access to Care

Primary Care Provider

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

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

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

Network Availability

Your network is subject to change 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.

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 *policy*.

Major Medical Expense Benefits

The Plan provides coverage for healthcare services for a member and/or dependents. Some services require preauthorization. Copayment amounts must be paid to your network provider at the time you receive services.

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

Benefit Limitations

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

Ambulance Service Benefits

Covered service expenses will include ambulance services for local transportation:

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

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.
5. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Autism Spectrum Disorder Benefits

Generally recognized services prescribed in relation to *autism spectrum disorder* by a *physician* or behavioral health practitioner in a treatment plan recommended by that *physician* or behavioral health practitioner.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- *applied behavior analysis*;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;

- physical therapy;
- *habilitation* services limited to children ages 0 to 21 with a diagnosis of *autism spectrum disorder*; or
- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Chiropractic Services

Chiropractic Services are covered when a Participating Chiropractor finds that the services are medically necessary to treat or diagnose Neuromusculoskeletal Disorders on an outpatient basis. Covered service expenses are subject to all other terms and conditions of the contract, including deductible amount and cost sharing percentage provisions. See the Schedule of Benefits for benefit levels or additional limits.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of diabetes. *Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine 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 (limited to one visit per episode), eye examinations, and prescription medication.

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

Dialysis Services

We cover medically necessary acute and chronic dialysis.

Covered expenses include:

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

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices

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

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

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

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

Covered services and supplies may include, but are not limited to:

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

Exclusions:

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

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

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

Medical and surgical supplies

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

Covered services and supplies may include, but are not limited to:

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

Exclusions:

Non *covered services* and supplies include, but are not limited to:

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

Medical Service Benefit

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

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

All Covered services are subject to conditions, exclusions, limitations, terms and provision of this policy.

Covered service must be medically necessary and not experimental or investigational.

Benefit Limitations:

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

Orthotic devices

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

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

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

Exclusions:

Non-covered services and supplies include, but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

Prosthetics

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

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

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

Covered services and supplies may include, but are not limited to:

1. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
7. Restoration prosthesis (composite facial prosthesis).
8. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

Exclusions:

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

1. Dentures, replacing teeth, or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).

6. Penile prosthesis in adults suffering impotency resulting from disease or *injury*.

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*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners*.
5. Outpatient physical therapy, occupational therapy, and speech therapy.

Cardiac rehabilitation is a *covered service* that is unlimited; however, it excludes cardiac rehabilitation services provided on a non-monitored basis and treatment for mental retardation.

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*.

Home Health Care Service Expense Benefits

Covered services and supplies 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 *medically necessary durable medical equipment*.
8. Sleep studies.

Charges under (4) 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 under the Home Health Care Service Expense Benefit.

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary care* under a *hospice care program*. *Covered services* and supplies 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 *policy* if the *member* had been confined in a *hospital*.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness*.
7. *Terminal illness counseling* of the *member's immediate family*.
8. *Bereavement counseling*.

Respite Services, provided as part of Hospice Care, are limited to 5 inpatient days/outpatient visits per 90 days.

Exclusions and Limitations:

Any exclusion or limitation contained in the *policy* 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.

Hospital Benefits

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

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

Medical and Surgical Expense Benefits

Medical *covered services* and supplies are limited to charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies.
2. Made by a *physician* for professional services, including *surgery*.
3. Made by an assistant surgeon.
4. For the professional services of a *medical practitioner*.

5. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
7. For chemotherapy and radiation therapy or treatment.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the *Schedule of Benefits* for benefit levels or additional limits.
12. 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.
13. For the following types of tissue transplants:
 1. Cornea transplants.
 2. Artery or vein grafts.
 3. Heart valve grafts.
 4. Prosthetic tissue replacement, including joint replacements.
 5. Implantable prosthetic lenses, in connection with cataracts.
14. Family Planning for certain professional *provider* contraceptive services and supplies, or its therapeutic equivalent, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices up to a 12-month supply per prescription. This also includes education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use.
15. Any type of hormone replacement therapy which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.
16. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
17. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
18. Allergy testing.
19. *Medically necessary* and *prior authorized prosthetic devices* are limited to one (1) item once every three (3) years.
20. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements, limitations and *cost sharing* as the same health care services when delivered to an insured in person.
21. Limited diagnostic and therapeutic infertility services determined to be *medically necessary* and *prior authorized*. *Covered services* do not include those services specifically excluded herein, but do include limited:
 1. Laboratory studies;
 2. Diagnostic procedures; and
 3. Artificial insemination services, up to six (6) cycles per *member* per lifetime.
22. *Prior authorized medically necessary* bariatric surgery, and complications from bariatric surgery, for extreme obesity under the following conditions:
 1. Have a body mass index (BMI) of greater than 40kg/m²; or
 2. Have a BMI greater than 35kg/m² with significant co-morbidities; and
 3. Can provide documented evidence that dietary attempts at weight control are ineffective; and
 4. Must be at least 18 years of age.
23. For *medically necessary* genetic blood tests.
24. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
25. For *medically necessary* allergy treatment.

26. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.

Mental Health and Substance Use Disorder Benefits

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

Our behavioral health and substance use vendor oversees the delivery and oversight of covered behavioral health and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our* behavioral health and substance use vendor's *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *Deductible amounts, copayment, or coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most recent edition of the International Classification of Diseases (ICD-10).

When making coverage determinations, *our* behavioral health and substance use vendor utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and substance use vendor utilizes Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance 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 and Outpatient mental health and/or *substance use disorder* services are as follows:

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive *Outpatient* Program (IOP);
3. Mental Health Day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and substance use;
6. Individual and group mental health evaluation and treatment;
7. Medication Assisted Treatment- combines behavioral therapy and medications to treat substance use disorders;
8. Medication management services;
9. Psychological and Neuropsychological testing and assessment;
10. Applied Behavioral Analysis for the treatment of autism;
11. Telemedicine; and
12. Electroconvulsive Therapy (ECT).

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

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

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 temporomandibular joint disorders (TMJ).

For dental expenses when a covered person suffers an injury, after the covered person's effective date of coverage, that results in:

- a. Damage to the member's 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;

Outpatient Medical Supplies Expense Benefits

Covered services and supplies for outpatient medical 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 year per *covered person*.
3. For four mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
6. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
7. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery.
8. For the cost of one hearing aid per *covered person*. Repairs and replacements are limited to once every three (3) years.

Pediatric Vision Expense Benefits

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

1. Routine vision screening, including dilation and with refraction every *calendar year*.
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal, or lenticular) in glass or plastic, or initial supply of *medically necessary* contacts every *calendar year*;
3. One pair of prescription frames per *calendar year*; and
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* care except when pre-*authorized*.

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*.

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

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For immunization agents, blood, or blood plasma, except when used for preventive care or required by ACA and listed on the formulary.
2. For medications used to treat obesity, unless specifically listed on the formulary.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
For more than a 34-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to 100-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network.

9. 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.
10. Off-label use, except as required by law or as expressly approved by *us*.
11. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
12. Drugs or dosage amounts determined by Ambetter to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
13. Foreign Prescription Medications, except those associated with an *emergency* medical condition while *you* are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
15. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to member's vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
16. Medications used for cosmetic purposes.
17. Cost sharing paid on your behalf for any prescription drugs obtained by you through the use of a drug discount, coupon, or copay card provided by a prescription drug manufacturer will not apply toward your plan deductible or your maximum out of pocket.

Topical Ophthalmic Products

A *member* can receive early refills of topical ophthalmic products in the following manner:

1. After 21 days or more but before 30 days after receiving any 30-day supply of the product;
2. After 42 days or more but before 60 days after receiving any 60-day supply of the product; or
3. After 63 days or more but before 90 days after receiving any 90-day supply of the product.

Prescription Drug Continuity of Coverage

A previously approved *prescription drug* order will be honored, unless after a reasonable investigation, it is determined by *your provider* that a different and presently approved drug is medically appropriate, safe, and effective in treating *your* medical condition.

Prescription Drug Synchronization

Under Nevada law *you* have the right to request synchronization of *your* medications. Synchronization is alignment of *your* fill dates so that all of *your* medication-refill dates are on the same day. For example, if *you* fill medication A on the 5th of each month and *your provider* prescribes *you* a new prescription B on the 20th of the month, *you* have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help *you* adjust *your* fill dates for medication B and synchronize the fill dates with medication A. We will adjust *copays* to reflect shorter or longer coverage. If *you* would like to exercise this right please call *our* Member Services line.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

External exception request review

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

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

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. A complete list of services is available at <https://www.leg.state.nv.us/nrs/NRS-695C.html#NRS695CSec1698>.
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 *deductible amounts*, *cost sharing percentage* provisions, and *copayment amounts* under the *policy* when the services are provided by a *network provider*. If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you're* getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges. If a member and/or dependents receive any other covered services during a preventive care visit, the member may be responsible to pay the applicable Copayment and Coinsurance for those Services.

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, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational 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.

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 forty five (45) years of age; or less than forty five (45) 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 *deductible amounts*, *coinsurance* provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from *deductible amounts*, *coinsurance* provisions, and *copayment amounts*, when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered service expenses* when required by the United States Secretary of Health and Human Services, but not later than one year after the recommendation or guideline is issued.

Cytological Screening

Covered service expenses include one annual cytologic screening test for a *member* beginning at age 18.

Ambetter from Nevada offers the following health management programs:

1. Asthma;
2. Coronary Artery Disease;
3. Diabetes (adult and pediatric);
4. Hypertension;
5. Hyperlipidemia;
6. Low Back Pain;
7. Tobacco Cessation.

To inquire about these programs or other programs available, you may visit our website at Ambetter.SilverSummitHealthplan.com or by contacting Member Services at 1-866-263-8134 (TDD/TTY: 1-855-868-4945).

HPV

Covered service expenses include immunization vaccines doses, recommended ages, and recommended populations vary for the Human Papillomavirus vaccine.

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 *covered person*. If the *covered person* is less than forty (40) years of age and 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.

Maternity Care

An inpatient stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a physician or other

healthcare provider obtain prior authorization. An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization.

Other maternity benefits which may require prior authorization include:

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

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

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

Newborns' and Mothers' Health Protection Act Statement of Rights

Health Insurance Issuers generally may not, under federal law, restrict benefits 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

Medical Foods

We cover medical foods and formulas for outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism. These special food products and enteral formulas are limited to 30 day supplies four (4) times per benefit year.

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

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 a *covered person* who is at least fifty (50) years of age; and at least once annually for a *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.

Covered Preventive Services for Women and Pregnant Women include:

1. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
2. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
3. Domestic and interpersonal violence screening and counseling for all *members*;
4. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
5. Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists, or its successor organization;
6. Screening for blood pressure abnormalities;
7. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
8. Cervical cancer screening for sexually active *members*;
9. Screening for depression;
10. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
11. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
12. Tobacco use screening and interventions for all *members*, and expanded counseling for pregnant tobacco users;
13. All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, or its successor organization; and
14. Well-woman visits to obtain recommended preventive services.

Respite Care Expense Benefits

Respite care is covered on an *inpatient* or outpatient basis to allow temporary relief to family members from the duties of caring for a *covered person* under Hospice Care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. See *your Schedule of Benefits* for coverage limits.

Second Medical Opinion

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

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

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

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

If we determine that a *member* is an appropriate candidate for a medically necessary *transplant*, medical service expense benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
7. Post-transplant follow-up.

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 *policy*;
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *medically necessary transplant*.

Ancillary "Center Of Excellence" Service Benefits:

A *member* may obtain services in connection with a *medically necessary transplant* from any *physician*.

However, if a *medically necessary transplant* is performed in a *Center of Excellence*:

1. *Covered service expenses* for the *medically necessary 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 *medically necessary 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 *medically necessary transplant*.
9. For a *medically necessary 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.
10. Left Ventricular Artificial Devices (LVAD) when used as destination.
11. Total artificial heart is not covered (even though it is a bridge to transplant).

Limitations on Transplant Service Expense Benefits:

In addition to the exclusions and limitations specified elsewhere in this section:

1. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

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, fees, taxes, or 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 *policy*. *You* will be fully responsible for payment for any services that are not *covered service expenses*.

Even if not specifically excluded by this *policy*, 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 *policy*, 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*, and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-therapeutic abortion.
6. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Major Medical Expense Benefits provision.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
13. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
14. For Mental health exams and services involving: 1) Services for psychological testing associated with the evaluation and diagnosis of learning disabilities 2) Marriage counseling 3) Pre-marital counseling 4) Court-ordered care or testing, or required as a condition of parole or probation 5) Testing of aptitude, ability, intelligence or interest 6) Evaluation for the purpose of maintaining employment, inpatient confinement, or inpatient mental health services received in a residential treatment facility unless associated with chemical or alcohol dependency in a nonmedical transitional residential recovery setting
15. Mental Health Services are excluded:

- a. for evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Plan Physician determines such evaluation to be Medically Necessary.
 - b. when ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.
 - c. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
16. Services which are custodial or residential in nature.
 17. Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
 18. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
 19. While confined primarily to receive *rehabilitation, custodial care*, educational care, or nursing services (unless expressly provided for in this *policy*).
 20. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
 21. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
 22. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
 23. For hearing aids, except as expressly provided in this *policy*.
 24. 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.
 25. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days.
 26. 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* workers' 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.
 27. As a result of:
 - a. An *injury or illness* caused by any act of declared or undeclared war.
 - b. The *member* taking part in a riot.
 - c. The *member's* commission of a felony, whether or not charged.
 28. For or related to surrogate parenting.
 29. For or related to treatment of hyperhidrosis (excessive sweating).
 30. For fetal reduction surgery.
 31. Except as specifically identified as a *covered service expense* under the *policy*, 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.
 32. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

33. 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.
34. 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.
35. 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 area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
36. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
37. For court ordered testing or care unless *medically necessary* or is required by law.
38. For a *member's illness* or *injury* which 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*.
39. Biofeedback

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 Policy

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

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

Refund upon Cancellation

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

Reinstatement

For coverage purchased outside the Health Insurance Marketplace, *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. For coverage purchased via the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew all policies 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 *policy*. 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 policies 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 policies in the individual market in the state where *you* reside.

Continuity of Care

We shall develop procedures to provide for the continuity of care of *members*. *We* shall ensure that when a *provider's* participation is terminated, the *provider's* patients under the plan may continue to receive care from that *provider* as an in-network benefit until a current episode of *medically necessary* treatment ends or until the end of 120 days, whichever occurs first. If the *member* is pregnant, then 45 days after the date of delivery or if the *pregnancy* does not end in delivery, the date of the end of the *pregnancy*.

Right of Reimbursement

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

If this plan provides benefits under this *policy* to a *member* for expenses incurred due to third party injuries, then SilverSummit Healthplan, Inc. retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the third party injuries.

SilverSummit Healthplan, Inc.’s rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

By accepting benefits under this plan, the *member* specifically acknowledges SilverSummit Healthplan, Inc.’s right of recovery. When this plan provides health care benefits for expenses incurred due to third party injuries, SilverSummit Healthplan, Inc. shall be included in the *member’s* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. SilverSummit Healthplan, Inc. may proceed against any party with or without the *member’s* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges SilverSummit Healthplan, Inc.’s right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to third party injuries and the *member* or the *member’s* representative has recovered any amounts from any source. SilverSummit Healthplan, Inc.’s right of reimbursement is cumulative with and not exclusive of SilverSummit Healthplan, Inc.’s right of recovery and SilverSummit Healthplan, Inc. may choose to exercise either or both rights of recovery.

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. To give SilverSummit Healthplan, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due SilverSummit Healthplan, Inc. as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
6. 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 entitled 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 the right of reimbursement independently of the *member*.
- 7. To take no action that prejudices *our* reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
- 8. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement rights.
- 9. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
- 10. 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.
- 11. That *we* may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse *us*.

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

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit. In the event *you* or *your* representative fail to cooperate with SilverSummit Healthplan, Inc., *you* shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by SilverSummit Healthplan, Inc. in obtaining repayment.

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 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 policies. 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 *hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
3. 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.
4. Plan whose benefits are by law excess to any private benefits coverage.
5. Individual plans.

"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 policy 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 *policy* will be primary.
4. Subject to State Statutes: 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 the person receiving services is the *member* and is covered under a separate stand-alone dental benefit plan, that stand-alone dental benefit plan shall be primary for services provided by an oral and maxillofacial surgeon.
8. 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 facts about health 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

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

Cooperation Provision

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

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 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. 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 20 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 30 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 *policy* 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 *policy* from any future benefits under this *policy*.

Foreign Claims Incurred For Emergency Care

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

Assignment

We will reimburse a *hospital* or 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 *policy* 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 *policy* 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 *policy* 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 *policy* 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 *policy*;
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*.

Legal Actions

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

No Third Party Beneficiaries

This *contract* is not intended to, nor does it, create or grant any rights in favor of any third party, including but not limited to any *hospital, provider* or *medical practitioner* providing services to *you*, and this *contract* shall not be construed to create any third party beneficiary rights.

Grievance and Complaint Procedures

Internal Procedures

Applicability/Eligibility

The internal *grievance* procedures apply to any hospital or medical policy or certificate or conversion plans, but not to accident only or disability only insurance.

An Eligible grievant is:

1. A claimant;
2. Person 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.

Important: *Adverse benefit determinations* that are not *grievances* will follow standard PPACA internal appeals processes.

Grievances

Claimants have the right to submit written 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.

Grievances will be promptly investigated and presented to the internal *grievance* panel. 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 an appeal. A request for an appeal must be submitted within 180 days following receipt of an *adverse benefit determination*.

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *claimant* and the *claimant's Authorized representative*, if applicable, written notification of the following within the first 30 calendar 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.
2. All other *grievances* will be resolved and we will notify the *claimant* in writing with the appeal decision within the following timeframes:
 - a. Post-service claim: within 30 calendar days after receipt of the *claimant's* request for internal appeal; or
 - b. Pre-service claim: within 30 calendar days after receipt of the *claimant's* request for internal appeal.

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 plan will give the claimant 10 calendar days to respond to the new

- information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to a later section for information regarding internal *expedited grievances*.

Acknowledgement

Within five business days of receipt of a *grievance*, a written acknowledgment to the claimant or the claimant's *Authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail.

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*; and
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.

Right to Appear

The claimant who filed the *grievance*, or the claimant's *Authorized representative*, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the claimant indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting; and
2. Reasonable accommodations must be provided to allow the claimant, or the claimant's *Authorized representative*, to participate in the *grievance* panel.

Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

1. At least one individual authorized to take corrective action on the *grievance*; and
2. At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care *provider* with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

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 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, 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

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination, or initiation of disenrollment.

The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
 - a. A clear explanation of the decision;
 - b. Reference to the specific plan provision on which the determination is based;
 - c. A statement that the claimant is entitled to receive, 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;
 - d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
 - e. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
 - g. The date of service;
 - h. The health care *provider's* name;
 - i. The claim amount;
 - j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
 - k. The health plan's denial code with corresponding meaning;
 - l. A description of any standard used, if any, in denying the claim;
 - m. A description of the external review procedures, if applicable;
 - n. The right to bring a civil action under state or federal law;

- o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
- p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
- q. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints

Basic elements of a *complaint* include:

- 1. The complainant is the claimant or an *Authorized representative* of the claimant;
- 2. The submission may or may not be in writing;
- 3. The issue may refer to any dissatisfaction about:
 - a. *Us*, as the insurer; e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me";
 - b. *Providers* with whom *we* have a direct or indirect contract;
 - i. Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
 - ii. Quality of care/quality of service issues;
- 4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*;
- 5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions; and
- 6. Any of the issues listed as part of the definition of *grievance* received from the *claimant* or the claimant's *Authorized representative* where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the State Insurance Department

The commissioner may require *us* to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a claimant as a *grievance* as appropriate. *We* will process the State Insurance Department *complaint* as a *grievance* when the commissioner provides *us* with a written description of the *complaint*.

External Review

An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.

We will pay for the costs of the external review performed by the independent reviewer.

You may request an external review from the Nevada Office for Consumer Health Assistance. *You* may contact the Office by writing to the Director, Consumer Health Assistance, 555 E. Washington Avenue, Ste. 4800, Las Vegas, Nevada 89101 or at any time by telephone at 1-888-333-1597

Applicability/Eligibility

The *grievance* procedures apply to:

- 1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance; or
- 2. Conversion plans.

After exhausting the internal review process, the claimant has four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.

- 1. The internal appeal process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process;

2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
 - a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*; and
 - b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received *emergency services*, but has not been discharged from a facility; and
3. Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.

External review is available for *grievances* 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

1. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - a. The individual was a *covered person* at the time the item or service was requested;
 - b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
 - c. The claimant has exhausted the internal process; and
 - d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete;
3. We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification;
4. We will assign an IRO on a rotating basis from *our* list of contracted IROs;
5. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider;
8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;

9. Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our adverse benefit determination*, *we* must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
10. Within 15 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to *us*. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, *we* will approve the covered benefit that was the subject of the *adverse benefit determination*.

Binding Arbitration

As a condition to becoming an Ambetter SilverSummit Policyholder, You agree to submit all disputes You may have with Ambetter SilverSummit, except those described below, to final and binding arbitration. You have the right to decline to participate in binding arbitration during the enrollment process. Likewise, Ambetter SilverSummit agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and Ambetter SilverSummit are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Ambetter SilverSummit's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between Ambetter SilverSummit and You (including Your enrolled Dependents, heirs or personal representatives) regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of Your Ambetter SilverSummit. Typically such disputes are handled and resolved through the Ambetter SilverSummit Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Ambetter SilverSummit uses binding Arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Ambetter SilverSummit involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration. Ambetter SilverSummit binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is \$200,000 or less (\$50,000 or less with respect to disputes with Ambetter SilverSummit involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to Ambetter SilverSummit, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000 or \$50,000, whichever is applicable. In the event that total amount of damages is over \$200,000 or \$50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to Ambetter SilverSummit, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then, in accordance with Nevada Insurance Code NRS 41A.003 to 41A.069, either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested

association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees. Arbitration can be initiated by submitting a demand for arbitration to Ambetter SilverSummit at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Ambetter SilverSummit Health Plan
2500 N. Buffalo Drive, Suite 250
Las Vegas, NV 89128

The arbitrator is required to follow applicable state or federal law and must be conducted pursuant to the rules for commercial arbitration established by the American Arbitration Association. The arbitrator may interpret this Policy, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Covered Person, Ambetter SilverSummit may assume all or portion of a Covered Person's share of the fees and expenses of the arbitration. Upon written notice by the Covered Person requesting a hardship application, Ambetter SilverSummit will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

The Nevada Division of Insurance is available to assist insurance consumers with insurance related problems and questions. *You* may inquire in writing to the Commissioner, Nevada Division of Insurance, 3300 W. Sahara Ave., Suite 275, Las Vegas, Nevada 89102 or contact the Department between the hours of 8 a.m. to 5 p.m. PST at 1-888-872-3234.

General Provisions

Entire Policy

This *policy*, with the application, is the entire *policy* between *you* and *us*. No agent may:

1. Change this *policy*;
2. Waive any of the provisions of this *policy*;
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 *policy* that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* 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 *policy*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* 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 *policy*.

Conformity with State Laws

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de SilverSummit Healthplan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-263-8134 (TTY/TDD 1-855-868-4945).
Tagalog:	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter from SilverSummit Healthplan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-263-8134 (TTY/TDD 1-855-868-4945).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from SilverSummit Healthplan 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 1-866-263-8134 (TTY/TDD 1-855-868-4945)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from SilverSummit Healthplan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-263-8134 (TTY/TDD 1-855-868-4945) 로 전화하십시오.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from SilverSummit Healthplan, 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 1-866-263-8134 (TTY/TDD 1-855-868-4945).
Amharic:	እርስዎ ወይም እርስዎ የሚርዳችሁ ሰው ለ Ambetter from SilverSummit Healthplan ጥያቄ ጥያቄ ስለሚገባዎት ወይም በጽንጽ ስለሚገባዎት መርሃ የሚገኝበት መስጫ ለእርስዎ ፡ ለአገልግሎት ለማግኘት በ 1-866-263-8134 (TTY/TDD 1-855-868-4945) ይደውሉ ፡
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีความเกี่ยวข้องกับ Ambetter from SilverSummit Healthplan ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพทติดต่อที่หมายเลข 1-866-263-8134 (TTY/TDD 1-855-868-4945).
Japanese:	Ambetter from SilverSummit Healthplan 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、1-866-263-8134 (TTY/TDD 1-855-868-4945) までお電話ください。
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from SilverSummit Healthplan ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ (1-866-263-8134 (TTY/TDD 1-855-868-4945).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from SilverSummit Healthplan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-866-263-8134 (TTY/TDD 1-855-868-4945).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from SilverSummit Healthplan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-263-8134 (TTY/TDD 1-855-868-4945).
Persian:	اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from SilverSummit Healthplan دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-866-263-8134 (TTY/TDD 1-855-868-4945) تماس بگیرید.
Samoan:	'Āfai e iai ni au fesili, po'o ni fesili fo'i a se isi 'o 'e fesoasoani i ai, e uiga i le Ambetter from SilverSummit Healthplan, e iai lau āiā e sa'ili ai ni fa'amatalaga i lau lava gagana e aunoa ma se togoti. 'A 'e fa'ialanoa i se fa'amatala'upu, telefoni le 1-866-263-8134 (TTY/TDD 1-855-868-4945).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from SilverSummit Healthplan 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 1-866-263-8134 (TTY/TDD 1-855-868-4945) an.
Ilocano:	No dakayo, wenno ti tultulunganyo, ket addaan iti saludsod maipapan ti Ambetter from SilverSummit Healthplan, addaankayo iti karbengan nga agpatulong ken dumawat iti impormasyon a naiyulog iti lengguaheyo nga awanan ti bayad. Tapno makasarita iti tao a mangiyulog iti sabali nga lengguahe, umawag iti 1-866-263-8134 (TTY/TDD 1-855-868-4945).

Statement of Non-Discrimination

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

Ambetter from SilverSummit Healthplan:

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

If you need these services, contact Ambetter from SilverSummit Healthplan at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

If you believe that Ambetter from SilverSummit Healthplan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from SilverSummit Healthplan Appeals Unit, 2500 North Buffalo Drive, Suite 250, Las Vegas, NV 89128, 1-866-263-8134 (TTY/TDD 1-855-868-4945), Fax 1-855-742-0125. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from SilverSummit Healthplan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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