ambetter. FROM | nh healthy families

2020 Evidence of Coverage

Ambetter.NHhealthyfamilies.com

75841 NH009-2020

IMPORTANT INFORMATION

THIS CONTRACT REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE NEW HAMPSHIRE INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.

AMBETTER FROM NH HEALTHY FAMILIES
UNDERWRITTEN BY CELTIC INSURANCE COMPANY

Home Office: 200 E. Randolph Street Chicago, Illinois 60601
Phone No. 1-844-265-1278
Ambetter.NHhealthyfamilies.com

Administrative Offices: Ambetter from NH Healthy Families, 2 Executive Park Drive Bedford, NH 03110
Claims Office: P.O. Box 25408 Little Rock, AR 72221

Individual Major Medical Expense Insurance Contract

In this contract, the terms you, your, or yours will refer to the member or dependents enrolled in this contract. The terms we, our, or us will refer to Celtic Insurance Company or Ambetter from NH Healthy Families.

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits* is your *contract* and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of your application and the timely payment of premiums, we will pay benefits to you, the member, for covered services as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

THIRTY-DAY RIGHT TO RETURN CONTRACT

Please read your contract carefully. This contract may, at any time within 30 days after its receipt by the contract holder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the contract will be deemed void from the beginning, and any premium paid on it will be refunded.

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 in to the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with contract terms. You may keep this contract (or the new contract that applies to you to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new contract each year, however, we may decide not to renew the contract as of the renewal date if: (1) we decide not to renew all contracts issued on this form, with a new contract at the same metal level with a similar type and level of benefits, to residents of the state where you then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a member in filing a claim for contract benefits.

75841 NH009-2020

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing the contract in the following events: (1) non-payment of premium; (2) a member moves outside the service area; (3) a member is found to be in material breach of this contract; or (4) 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 contract form. Each premium will be based on the rate table in effect on that premium's due date. The contract plan, and age of members, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed through the end of the current calendar year.

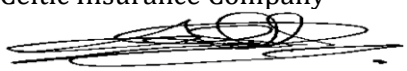
At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this contract or a change in a member's health. While this contract is in force, we will not restrict coverage already in force.

The coverage represented by this contract is under the jurisdiction of the New Hampshire Insurance Commissioner.

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

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

Celtic Insurance Company



Anand Shukla
SVP, Individual Health – Celtic Insurance Company

TABLE OF CONTENTS

INTRODUCTION

Welcome to Ambetter from NH Healthy Families! We have prepared this *contract* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

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

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

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

How to Contact Us
Ambetter from NH Healthy Families
2 Executive Park Drive
Bedford, NH 03110

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST, Monday through Friday

Member Services	**1-844-265-1278**
TDD/TTY line	**1-855-742-0123**
Emergency	**911**
24/7 Nurse Advice Line	**1-844-265-1278**

Interpreter Services
Ambetter from NH Healthy Families has a free service to help *members* who speak languages other than English. These services ensure that *you* and *your physician* can talk about *your* medical or behavioral health concerns in a way that is most comfortable for *you*.

Our interpreter services are provided at no cost to *you*. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a *provider's* office with you. *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 1-844-265-1278 or for the hearing impaired (TDD/TTY 1-855-742-0123).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

If *you* have difficulty locating a *primary care provider*, specialist, *hospital* or other contracted provider please contact us so we can assist you with access or in locating a contracted Ambetter provider. Ambetter *physicians* may be affiliated with different *hospitals*. *Our* online directory can provide *you* with information on the Ambetter contracted *hospitals*. The online directory also lists affiliations that *your* provider may have with non-contracted *hospitals*. Your Ambetter coverage requires *you* to use contracted providers with limited exceptions.

You have the right to:

1. Participate with *your providers* in decisions about *your* healthcare. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally *authorized* surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *providers*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from *your primary care provider* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care provider* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally *authorized* person. *Your 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 provider 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, race, sex, sexual orientation, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care provider* within the *network*. *You* also have the right to change your *primary care provider* or request information on *network providers* close to *your* home or work.
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 provider*.
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. They can help *your primary care provider* and other providers understand *your* wishes about *your* health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for *yourself*. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. *Member*s also have the right to refuse to make advance directives.

You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your physician*. *You* may change *your primary care provider* verbally or in writing by contacting *our Member* Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* healthcare professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* healthcare professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *physician*.
11. Tell *your* healthcare professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any *emergency* room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. Provide all information about any other medical coverage *you* have upon enrollment in this plan. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* enrolled.
15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts*, or *coinsurance* at the time of service.
16. Inform the entity (either the Marketplace or *us*) in which *you* enrolled to obtain 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.

IMPORTANT INFORMATION

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

At any time, *you* can request a printed copy of the provider directory at no charge by calling Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123). In order to obtain benefits, *you* may designate a *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 provider*'s office if *you* want to make an appointment. If *you* need help, call Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123). *We* will help *you* make the appointment.

Member ID Card
When *you* enroll, *we* will mail a *member* ID card after *we* receive *your* completed enrollment materials and have paid *your* initial premium payment. This card is proof that *you* are enrolled in an Ambetter from NH Healthy Families plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, and *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 1-844-265-1278 (TDD/TTY 1-855-742-0123). *We* will send *you* another card.

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.NHhealthyfamilies.com. It also gives *you* information on *your* benefits and services such as:

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

9. *Deductible* and *Copayment* Accumulators.
10. Making *your* payment.

Quality Improvement

We are committed to providing quality service 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. Providing programs and educational items about general healthcare and specific diseases.
3. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee that includes *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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

DEFINITIONS

In this contract, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this contract:

Action means the denial or limited authorization of a requested service, including they type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure of the health plan to provide services in a timely manner as defined in the appointment standards described herein; or the failure of the health plan to act within timeframes for the health plan's prior authorization review process specified herein.

Acute rehabilitation is rehabilitation for patients who will benefit from an intensive, multidisciplinary rehabilitation program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained physicians. Rehabilitation services must be performed for three or more hours per day, five to seven days per week, while the *member* is confined as an inpatient in a *hospital*, *rehabilitation facility*, or *extended care facility*.

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

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

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a covered benefit.
3. A determination that an admission, continued stay, or other health care service does not meet *our* requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental, investigational, cosmetic treatment,* not *medically necessary* or inappropriate.

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

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

Allowed Amount (also ***Eligible Expense***) is the maximum amount *we* will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *member's* benefits.

Please note, if *you* receive services from a *non-network provider*, *you* may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that *we* pay. This is known as *balance billing* – see *balance billing* and *non-network provider* definitions for additional information.

Appeal means a request for a plan to reconsider a previous decision including an *action*.

Applied behavioral analysis is endorsed by the US Surgeon General, The American Academy of Pediatrics and National Institutes of Child Health and Human Development. This scientifically proven treatment is intensive and individualized therapy useful for gains in all developmental areas including social, language, and behavioral.

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

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

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

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

Authorization or ***Authorized*** (also "***Prior Authorization***" or "**Approval**") means *our* decision to approve the *medically necessary* or the appropriate care for a *member* by the *member's* PCP or provider group before the *member* receives services.

Balance Billing means a *non-network provider* billing *you* for the difference between the provider's charge for a service and the *eligible expense*. *Network providers* may not *balance bill you* for *covered service expenses.* A health care provider performing anesthesiology, radiology, emergency medicine, or pathology services shall not *balance bill you* for fees or amounts other than *copayments*, *deductibles*, or *coinsurance*, if the service is performed in a *hospital* or ambulatory surgical center that is in-network under the patient's health insurance plan. This prohibition shall apply whether or not the health care provider is contracted with the patient's insurance carrier.

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.

Billed Amount is the amount a provider charges for a service.

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

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

Center of Excellence means a *hospital* that:

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

You can call member services, go onto your member portal, or ask your physician, who in return could look up the CPT code to determine if his/her facility is a "Center of Excellence."

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.

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

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia,

missed abortion, and similar medical 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*.

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

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

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

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

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

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

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

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

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

Custodial care includes but is not limited to the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;

3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, *sanatoria care*, educational care or recreational care.

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

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

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 *contract* for *covered services*.

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

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

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

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

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

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

Emergency means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention such that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that failure to provide medical attention could result in:

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

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, *emergency* services, hospitalization, maternity and newborn care, mental health and *substance use* disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care*. Essential Health Benefits* provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-*essential health benefits*, however, are subject to either a lifetime and/or annual dollar maximum.

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

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the *claimant* to regain maximum function;
2. In the opinion of a *physician* with knowledge of the *claimant's* medical condition, the *claimant* is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
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 healthcare services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

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

listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

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

Items (2) and (3) above do not apply to phase III or IV *USFDA* clinical trials.

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

1. Is operated pursuant to law 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 use, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

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

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

Grievance means an expression of dissatisfaction about any matter other than an *action*. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes grievances and appeals handled at the Plan level.

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

Hearing care professional means a person who is a licensed audiologist, a licensed hearing instrument dispenser, or a licensed *physician*.

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

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

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

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

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

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

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

Hospice refers to services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by your attending *physician* or Primary Care Provider. Ambetter works with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of terminally ill members and their immediate family.

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, transitional facility, or a patient is moved from the emergency room in a short term observation status, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*.

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

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

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

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

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

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

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

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

reference to any of the foregoing;

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

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

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

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

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

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

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

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

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

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

Medically necessary or ***medical necessity*** means any medical service, supply or treatment to prevent, stabilize, diagnose or treat a *member's illness,* or *injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not solely for the convenience of the *physician* or the *member*;
4. Is not *experimental or investigational*; and
5. 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.

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

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

Mental disorder means a behavioral, emotional, or cognitive disorder that is listed in the most recent edition of the International Classification of Diseases, Eleventh Revision (ICD-11).

Necessary medical supplies mean medical supplies that are:

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

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

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

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

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

Non-elective caesarean section means:

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

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

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 contract that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, 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 means services that include facility, ancillary, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by us. Professional charges only include services billed by a Physician or other professional.

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

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

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *member* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the healthcare system. A *pain management program* must

be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

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

Post-service claim means any claim for benefits for medical care or treatment that has already been provided.

Practice of fitting, dispensing, servicing, or sale of hearing instruments means the measurement of human hearing with an audiometer, calibrated to the current American National Standard Institute standards, for the purpose of making selections, recommendations, adoptions, services, or sales of hearing instruments including the making of ear molds as a part of the hearing instrument.

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the *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 service expenses*, shown in the Schedule of Benefits, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses*.

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

Primary care provider (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 *contract*. 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* receiving 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.

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 45 CFR 156 part C issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in 45 CFR 155, part K.

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 *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

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

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

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

Rehabilitation 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, cardiac therapy, or respiratory therapy.

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

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

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

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

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

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

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

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

Social determinants of health are the circumstances in which people are born, grow up, live, work, and age. This also includes the systems in place to offer health care and services to a community.

Specialist provider is a *physician* or medical practitioner who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or illnesses. Specialists may be needed to diagnose, manage, prevent, or treat certain types of symptoms and conditions related to their specific field of expertise.

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

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

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

Surgery or ***surgical procedure*** means:

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

Surrogacy Arrangement means an understanding in which a woman (the *surrogate*) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the *surrogate* receives payment for acting as a *surrogate*.

Surrogate means a gestational carrier who, as part of a *surrogacy arrangement*, (a) uses her own egg that is fertilized by a donor or (b) has a fertilized egg placed in her body but the egg is not her own.

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 contract under which the *member* is entitled to benefits as a named insured person or an insured *dependent* 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 if within the six months immediately preceding the date application for this *contract* was completed by the *member*. Tobacco use includes all tobacco products but does not include religious and ceremonial uses of tobacco.

Transcranial magnetic stimulation (TMS) is a non-invasive procedure in which a changing magnetic field is used to cause electric current to flow in a small targeted region of the brain via electromagnetic induction.

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; and
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 an appropriately licensed facility, not including a *hospital emergency* room or a *physician's* office, that provides treatment for a medical or mental health condition or symptomatic illness of a covered person that if not treated within 48 hours presents a risk of serious harm.

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

DEPENDENT MEMBER COVERAGE

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

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

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

Coverage for a Newborn Child
An *eligible child* born to a *covered person* will be covered from the time of birth until the 31st day after its birth. You are required to notify the entity you enrolled with (Marketplace or *us)* within 60 days of the newborns birth.

However, in order to continue coverage after the 31st day of the newborn's birth, a premium is required. Payment for premium will start on the 32nd day after the date of birth for coverage of the newborn to continue past 31 days. Coverage of the child will terminate on the 31st day after the newborn's birth, if we have not received notice of the addition of the newborn to your policy and you have not paid premium to continue coverage past the 31st day. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

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

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

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

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

The qualifying events for policies purchased on and off the exchange are the same. However, for off exchange policies, notice of the adoption or birth of a child must been given to us directly within the

31 day timeframe.

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

If *you* have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact Member Services Department at 1-844-265-1278 (TDD/TTY 1-855-742- 0123).

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

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter coverage will apply for covered benefits related to the *inpatient* coverage after *your effective date*. Ambetter coverage requires *you* notify Ambetter within 2 days of *your effective date* so we can review and authorize *medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the Ambetter *allowed amount* and *you* may be billed for any balance of costs above the Ambetter *allowed amount*.

ONGOING ELIGIBILITY

Open Enrollment
There will be an open enrollment period for coverage. The Open Enrollment period begins November 1, 2019 and extends through December 15, 2019. *Qualified Individuals* who enroll prior to December 15, 2019 will have an *effective date* of coverage on January 1, 2020.

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

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

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

1. A *Qualified individual* or *dependent loses minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;
2. A *Qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption or placement for adoption, placement in foster care, or a child support order or other court order; a. In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *Qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee's decision to purchase the qualified health plan based on plan benefits, service area or premium;
7. An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;

8. A *Qualified individual* or enrollee gains access to new *qualified health plan* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month;
11. A *Qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A qualified individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A qualified individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or
14. At the option of the Health Insurance Marketplace, a qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified health plan through the Health Insurance Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

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

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

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

PREMIUMS

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

When a *member* is not receiving a premium subsidy:

> Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a thirty-one (31) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

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

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Family members; or
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial

relationship, or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the calendar year.

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

Similarly, if *we* determine payment was made for *deductibles* or *cost sharing* by a third party, such as a drug manufacturer paying for all or part of a medication, that shall be considered a third party premium payment that may not be counted towards *your deductible* or *maximum out-of-pocket* costs.

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

If *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. *We* receive from *you* a written request for reinstatement within 60 days after the date coverage lapsed; and
2. The written request for reinstatement is accompanied by the required premium payment.

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

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

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

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

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

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.

When *you*, or a covered dependent, receive health care services from a *provider*, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or *provider* to treat a condition or an *illness*. Each claim that we receive for services covered under this *contract* are adjudicated or processed as we receive them. Coverage is only provided for *eligible expenses*. Each claim received will be processed separately according to the cost share as outlined in the *contract* and in your *schedule of benefits*.

Copayments

A *copayment* is typically a fixed amount due at the time of service. *Member*s may be required to pay *copayments* to a provider each time services are performed that require a *copayment*. *Copayments* are due as shown in the *Schedule of Benefits*. Payment of a *copayment* does not exclude the possibility of a provider billing you for any non-*covered service*. *Copayments* do not count or apply toward the *deductible amount*, but do apply toward *your maximum out-of-pocket* amount.

Coinsurance

A *coinsurance amount* is *your* share of the cost of a service. *Members* may be required to pay a *coinsurance* in addition to any applicable *deductible amount(s)* due for a *covered service* or supply. *Coinsurance* amounts do not apply toward the *deductible* but do apply toward *your maximum out-of-pocket* amount. When the annual *out-of-pocket* maximum has been met, additional *covered service expenses* will be 100%.

Deductible

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

Maximum Out-of-pocket

You must pay any required *copayments* or *coinsurance amounts* required until *you* reach the *maximum out-of-pocket* amount shown on your *Schedule of Benefits*. After the *maximum out-of-pocket* amount is met for an individual, we will pay 100% of the cost for *covered services*. The family *maximum out-of-pocket* amount is two times the individual *maximum out-of-pocket* amount. For the family *maximum out-of-pocket* amount, once a *member* has met the individual *maximum out-of-pocket* amount, the remainder of the family *maximum out-of-pocket* amount can be met with the combination of any one or more *members' eligible expenses*.

Refer to your Schedule of Benefits for Coinsurance and Other Limitations
The amount payable will be subject to:

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

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum. A non-*network provider* may not charge you fees or amounts, other than *cost sharing* amounts, for anesthesiology, radiology, *emergency* medicine, or pathology services, if the service is performed in a *hospital* or ambulatory surgical center that is a *network provider*.

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

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

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

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

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

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*; or
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; or
4. Ambulance services provided for a *member's* comfort or convenience.
5. Non-*emergency* transportation excluding ambulances (for example- transport van, taxi).

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

1. Upon request by *us*, a *provider* of treatment for *autism spectrum disorder*s shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is intended to maintain, develop, or improve *member's* clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, *we* may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.
2. When making a determination of medical necessity for a treatment modality for *autism spectrum disorder*s, *we* will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an appeals process. During the appeals process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a *physician* with expertise in the most current and effective treatment modalities for *autism spectrum disorder*s. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
3. Habilitation services, for *member*s with a diagnosis of *autism spectrum disorder*, at a minimum shall include: *applied behavior analysis* that is intended to develop, maintain, or restore the functioning of an individual.
4. Professional services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board.

Clinical Trials for Cancer and Other Life-Threatening Illnesses
Covered service expenses for the routine patient care costs incurred by a *member* enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, if the *member's physician* determines that:

1. There is no clearly superior non-investigational treatment alternative; and
2. Available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-investigational alternative.

Covered service expenses include the costs of:

1. prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a healthcare insurance plan if the medical care were not in connection with an approved clinical trial;

3. items or services necessary to provide an investigational item or service;
4. the diagnosis or treatment of complications;
5. a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;
6. services necessary to administer a drug or device under evaluation in the clinical trial; and
7. transportation for the patient that is primarily for and essential to the medical care.

Covered service expenses do not include:

1. drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;
2. housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
3. an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
4. an item or service excluded from coverage under the patient's healthcare insurance plan; and
5. an item or service paid for or customarily paid for through grants or other funding.

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

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

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

Dialysis Services
Medically necessary acute and chronic dialysis services are covered benefits unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment provided you meet all the criteria for treatment. You may receive hemodialysis in an in-network dialysis facility or peritoneal dialysis in *your* home from a *network provider* when *you* qualify for home dialysis.

Covered expenses include:

1. Services provided in an outpatient dialysis facility or when services are provided in the home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a hospital; and

4. 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* 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. *W*e will determine if equipment is made available on a rental or purchase basis. At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a *provider we* authorize before the purchase.

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

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

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

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by *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:

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

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

<u>Durable medical equipment</u>
The rental (or, at *our* option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs,

crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

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

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

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

<u>Medical and surgical supplies</u>
Certain supplies and equipment for the management of disease that we approve are covered under the Prescription Drug benefit.

Covered Services may include, but are not limited to:

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

Exclusions:
Non Covered Services include but are not limited to:

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

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

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

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

Covered Services may include, but are not limited to:

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

6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs

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. Penile prosthesis in men suffering impotency resulting from disease or injury.

Orthotic devices

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

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

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

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

Exclusions:
Non-covered services include but are not limited to:

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

Hearing Aids: For the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or *hearing aids*. The benefits includes the cost of a *hearing aid* for each ear, as needed, as well as related services necessary to assess, select, and fit the *hearing aid*, as needed.

Habilitation, Rehabilitation and *Extended Care Facility* Expense Benefits
Covered service expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration;
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Coverage for a Skilled Nursing Facility is limited to 100 days per year.
6. *Habilitation* and *Rehabilitation* Services are limited to 20 visits per year per therapy (Occupational Therapy, Physical Therapy and Speech Therapy).
7. Coverage for Cardiac Rehabilitation.

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

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

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

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

Home Healthcare Expense Benefits
Covered service expenses and supplies for home health care are covered when *your physician* indicates *you* are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary* in-network care provided at the *member's* home and includes the following:

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist

required for *home healthcare;*

3. I.V. medication and pain medication;
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*;
6. Rental or purchase of *medically necessary durable medical equipment*. 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.
7. Sleep studies.
8. Intermittent skilled nursing services by an R.N. or L.P.N.
9. Medical / social services.
10. Diagnostic services.
11. Nutritional guidance.
12. Training of the patient and/or family/caregiver.
13. Prenatal and postpartum homemaker visits.

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

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

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

Hospice Care Expense Benefits
Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice care program*. *Covered services* 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 member* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital;*
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 members of the *member's immediate family;* and
8. *Bereavement counseling*.

For each day the *member* is confined in a *hospice,* benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is

associated.

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

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

Respite Care Expense Benefits
Respite care is covered on an *inpatient*, home or *outpatient* basis to allow temporary relief to family *member*s 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.

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* for use only while *you* are *inpatient.*
6. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your* Schedule of Benefits for limitations.

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

Mammography Coverage
Typical breast cancer screening mammography, which includes the following:

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

treatingthe *member*.

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

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

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *member*s for the diagnosis and *medically necessary* and active treatment of mental, emotional, 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 or the International Statistical Classification of Diseases and Related Health Problems (ICD).

When making coverage determinations, *our* behavioral health and substance use vendor utilizes established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and substance use vendor utilizes McKesson's Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive *Outpatient* Program (IOP);

3. Mental Health Day Treatment;
4. *Outpatient* detoxification programs;
5. Evaluation and assessment for mental health and substance use;
6. Individual and group therapy for mental health and substance use;
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. Obsessive Compulsive disorder, including pediatric autoimmune neuropsychiatric disorders;
11. Applied Behavioral Analysis for treatment of autism;
12. Telehealth;
13. Electroconvulsive Therapy (ECT); and
14. Transcranial Magnetic Stimulation (TMS)

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

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

Medical and Surgical Expense Benefits
Covered service expenses are limited to charges:

1. For surgery in a *physician's* office, inpatient facility or at an *outpatient surgical facility,* including services and supplies;
2. For services received for urgent care, including facility charges at an *urgent care center*.
3. Made by a *physician* for professional services, including *surgery;*
4. Made by an assistant surgeon;
5. For the professional services of a *medical practitioner;*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services;
8. For chemotherapy and radiation therapy or treatment;
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
10. For the cost and administration of an anesthetic;
11. For oxygen and its administration;
12. For *dental expenses* when a *member* suffers an *injury,* that results in:
    a. Damage to his or her sound natural teeth and gums;
    b. Expenses are incurred or treatment is *authorized* as part of a treatment plan that was prescribed by a *physician*. *Injury* to the natural teeth will not include any injury as a result of chewing; and
    c. Treatment made necessary due to injury to the jaw and oral structures other than

teeth are covered without time limit;

13. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer, if the patient elects reconstruction and in the manner chosen by the patient and the *physician*. 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;
14. For *surgery*, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, as well as removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services;
15. For Chiropractic Care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary manipulative therapy* treatment on an outpatient basis and physiological therapy before (or in conjunction with) spinal adjustment. This benefit is limited to 12 visits per year;
16. For pulse oximetry screening on a newborn;
17. For *medically necessary* transplants:
18. For *outpatient contraceptive services* for any type of drug or device for contraception, which is lawfully prescribed and has been approved by the FDA. Coverage for prescription contraceptives will be provided for a 12-month period, if prescribed in that quantity. Additionally, coverage is required for any outpatient services related to the use of a drug or device intended to prevent *pregnancy.* Benefits for prescription *outpatient contraceptive services* are exempt from any *deductible*s, *copayment* and *coinsurance* provisions;
19. For dental procedure coverage for the medically necessary facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a *member* who:
    a. is a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed *primary care provider* to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or *hospital* setting; or
    b. is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed *primary care provider* which place the person at serious risk;
20. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is medically necessary and is the least restrictive and most cost effective means for meeting the needs of the *member*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein;
21. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury.
22. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months

of age with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's primary care provider if applicable;

23. For the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing physician has issued a written order stating that treatment is medically necessary and in accordance with the member's qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post- operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. The covered insured person shall be at least 18 years of age;
24. For medically necessary diagnostic and laboratory and x-ray tests;
25. For telemedicine for covered services provided within the scope of practice of a physician or other healthcare provider as a method of delivery of medical care by which a member shall receive medical services from a healthcare provider without in-person contact with the provider;
26. For naturopathy providers;
27. For injections, including allergy injections;
28. For Medically Necessary oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is Medically Necessary to attain functional capacity of the affected part.
    c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
    d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. Reconstructive surgery.
29. For *medically necessary* genetic blood tests.

Outpatient Medical Supplies Expense Benefits
Covered service expenses for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *member* and the item cannot be modified. If more than one prosthetic device can meet a *member's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered service expense*;
2. For one pair of foot orthotics per year per *member*;

3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
4. For the rental cost of one Continuous Passive Motion (CPM) machine per *member* following a joint surgery;
5. Infusion therapy;
6. For one pair of eyeglasses or contact lenses per *member* following a cataract surgery, or if the lens of *your* eye has been surgically removed or is congenitally absent; and
7. For any other use of a drug approved by the United States Food and Drug Administration when the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include *medically necessary* services associated with the administration of the drug. This benefit shall not be construed to require:
    a. Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
    b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
    c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this *contract.*

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

Other maternity benefits include:

1. 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. This does not require prior authorization as it is part of Maternity Care.
2. Physician Home Visits and Office Services. Physician Services require prior authorization due to any services done in the home requiring prior authorization. Office visit do not require prior authorization.
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. This does not require prior authorization as it is part of Maternity Care.
4. Complications of pregnancy. This does not require prior authorization as it is part of Maternity Care.
5. Hospital stays for other medically necessary reasons associated with maternity care. This does not require prior authorization as it is part of Maternity Care.

The only circumstance you would need to obtain prior authorization would be for physician home visits, as any service done in the home requires prior authorization. You can reference the Evidence of Coverage; call member services, go onto your member portal, or ask your physician, who in return could look up the CPT

code for the service in the pre-screen tool on the NH website.

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.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please see General Non-Covered Services and Exclusions.

Duty to Cooperate. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* in accordance with the notice requirements set forth in General Provisions herein. In the event that a *member* fails to comply with this provision, *we* reserve *our* right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under *our* policy, plus interest, attorneys' fees, costs and all other remedies available to *us*.

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

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

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a *physician* or other healthcare provider obtain *authorization* for prescribing a length of stay of up to 48 hours or 96 hours.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

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

1. A *prescription drug;*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*;

3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. 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; and
4. Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

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.

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

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician. Experimental or investigational treatment* drugs will be covered as defined.

Prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which *member*s may obtain coverage for a *medically necessary* non-formulary prescription drug. The exception process shall begin when the prescribing provider has provided the clinical rationale for the exception. The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to Ambetter from NH Healthy Families. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

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 expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

Exception for drugs available on the formulary during previous 12 months
For any non-formulary drug that was available as formulary product during previous 12 months, you have the right to request a formulary exception. To request a formulary exception please call our vendor Envolve

Pharmacy Solutions at 1-866-399-0928. You or your provider can also request a formulary exception through faxing the request to 1-866-399-0929.

Emergency prescription supply
For non-formulary drugs removed from the formulary during previous 90 days, you have the right to request an emergency 72-hour prescription supply. To request a 72-hour emergency prescription supply please call the customer service number on the back of your ID card.

Notification of formulary changes
We will notify you of any formulary changes at least 45 days in advance of such changes. We will provide you with instructions on how to request a formulary exception for non-formulary drugs and an emergency supply.

Notice and Proof of Loss:
In order to obtain payment for *covered service expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

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, tier status as indicated by the formulary will be applicable.

Prescription refills are subject to the following:

Ophthalmic prescriptions

Refills for ophthalmic prescription medications based on days supply of the original fill or the most recent fill of the prescription.

For a 30-day supply of an ophthalmic prescription, the member can request the refill no earlier than 21 days after the following dates:

- The date the original prescription was dispensed to the member; or
- The date the most recent refill of the prescription was dispensed to the member.

For example, if member fills a 30-day supply of a medication on April 1st, the member can refill the same medication on or after April 21st.

For a 90-day supply of an ophthalmic prescription, the member can request a refill no earlier than 63 days after the later of the following dates:

- The date the original prescription was dispensed to the member
- The date the most recent refill of the prescription was dispensed to the member.

For example, if member fills a 90-day supply of an ophthalmic medication the member will be able to refill that ophthalmic medication on the 63rd day after the original or most recent fill of the medication.

Non-ophthalmic prescriptions

Refills for non-ophthalmic prescription medications are provided after member uses 80% of medication available based on days supply of the original fill or the most recent fill of the prescription.

For example, if member fills a 30-day supply of medication on April 1st, member can refill the same medication on or after April 25th. For non-ophthalmic medications, we may utilize supply-on-hand logic limiting *member* to 5 fills in any rolling 6 month period. For example, if *member* fills first fill of medication on January 1st and utilizes early refill (when 80% of previous claim has been utilized) *member* will have 6 month supply on-hand after the 5th fill. *We* may limit further refills until *member* has exhausted total supply.

Non-Covered Services and Exclusions:
No benefits will be paid under this benefit subsection for expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For weight loss prescription drugs unless otherwise listed on the formulary;
3. For immunization agents, blood or blood plasma, except when used for preventive care and listed on the formulary;
4. For medication that is to be taken by the *member*, in whole or part, at the place where it is dispensed;
5. For medication received while the *member* is a patient at an institution, that has a facility for dispensing pharmaceuticals;
6. For a refill dispensed more than 12 months from the date of a *physician's* order;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program;
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs are limited to 30-day supply when dispensed by retail or mail order;
12. 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;
13. Foreign Prescription Medications, except those associated with an *Emergency* Medical Condition while *you* are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States;
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country

travel. This section does not prohibit coverage of treatment for aforementioned diseases;

15. Medication used for cosmetic purposes;
16. For infertility drugs unless otherwise listed on the formulary;
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations;
18. 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 such drugs or dosage amounts have been approved by any governmental regulatory body for that use;
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis where drug administration occurs at dental practitioner's office;
20. For any drug dispensed from a non-lock-in pharmacy while member is in opioid lock-in program (see Lock-in Program provision below);
21. For any drug related to surrogate pregnancy;
22. For any drug used to treat hyperhidrosis;
23. 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;
24. Medications used for cosmetic purposes;
25. For any claim submitted by non lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims (see Lock-in Program provision below; or
26. For prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.

Lock-in program
To help decrease opioid over-utilization and abuse, certain members identified through our Lock-in Program may be locked into a specific pharmacy for the duration of their participation in the lock-in program. Members locked into a specific pharmacy will be able to obtain their medication(s) only at a specified location. Ambetter pharmacy, together with Medical Management will review member profiles and using specific criteria, will recommend members for participation in the lock-in program. Members identified for participation in the lock-in program and associated providers will be notified of member participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which member is locked-in and any appeals rights.

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

Pediatric Vision Expense Benefits
Coverage for vision services is provided for children, under the age of 19, from a *network provider* through the end of the plan year in which they turn 19 years of age.

1. Routine ophthalmological exam

a. Refraction;
b. Dilation;
c. Contact lens fitting.

2. Frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or
    e. Contact lenses (in lieu of glasses).
4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium);
    b. Intermediate vision lenses;
    c. Blended segment lenses;
    d. Hi-Index lenses;
    e. Plastic photosensitive lenses;
    f. Photochromic glass lenses;
    g. Glass-grey #3 prescription sunglass lenses;
    h. Fashion and gradient tinting;
    i. Ultraviolet protective coating;
    j. Polarized lenses;
    k. Scratch resistant coating;
    l. Anti-reflective coating (standard, premium or ultra);
    m. Oversized lenses;
    n. Polycarbonate lenses.
5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

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

Services not covered:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Non-*network* care without *prior authorization*.

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;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women;
5. All FDA-approved contraception methods (identified on www.fda.gov) are approved for *member*s without *cost sharing* as required under the Affordable Care Act. *Member*s have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without *cost share*. Some contraception methods are available through a *member*'s medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *member*;
    a. Per ACA requirements, condoms and vasectomies are not covered as preventive.
6. Covers without *cost sharing*:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior *authorization*; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior *authorization*.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible*s and *coinsurance* provisions under the *contract* when the services are provided by a *network provider.* Benefits include coverage for smoking cessation counseling and related prescription drugs.

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

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

If a 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.

Transplant Service Expense Benefits
Covered services and supplies for transplant service expenses:

Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *contract*. Transplant services must be provided by an in-network provider and facility, and meet other medical criteria as set by medical management policy and the medical providers performing the transplant.

If *we* determine that a *member* is an appropriate candidate for a *medically necessary* transplant, Medical Benefits *covered service expenses* 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. Coverage for laboratory fee expenses up to $150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow transplantation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the *member* tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program. Pursuant to RSA 451:6-m, II., the testing facility should not *balance bill you* for any remaining portion of the laboratory fee expenses; and
8. Post-transplant follow-up.

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

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

3. The transplant was a medically necessary.

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

1. *Covered service expenses* for the transplant will include the acquisition cost of the organ or bone marrow; and
2. *We* will pay a maximum of $10,000 per lifetime 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.

Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs;
2. For animal to human transplants;
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
4. To keep a donor alive for the transplant operation;
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ; and
6. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations on Transplant Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section, if a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Urgent Care

Urgent care services include *medically necessary* services by in-network providers and services provided at an *urgent care center* including facility costs and supplies. Care that is needed after a *primary care provider's* normal business hours is also considered to be urgent care. Your zero *cost sharing* preventive care benefits may not be used at an *urgent care center*.

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another provider, but contracted *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-844-265-1278. The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

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*.

Health Management Programs Offered
Ambetter from NH Healthy Families offers the following health management programs:

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

To inquire about these programs or other programs available, you may visit our website at Ambetter.NHhealthyfamilies.com or by contacting Member Services at 1-844-265-1278.

Social Determinants of Health Supplemental Benefits
Social determinants of health supplemental benefits and services may be offered to *members* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that *we* may make available in connection with this *contract*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by *us*. Upon termination of coverage, the benefits are no longer available. All *members* are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the *members*. The benefits and services available at any given time are made part of this *contract* by this reference and are subject to change by *us* through an update to information available on *our* website or by contacting *us*.

Social determinants of health benefits and services may be offered to *members* through the "My Health Pays" wellness program and through local health plan websites. *Members* may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit *our* website at Ambetter.NHhealthyfamilies.com or by contacting Member Services at 1-844-265-1278 (TDD/TTY 1-855-742-0123).

Wellness and Other Program Benefits
Benefits may be available to enrollees for participating in certain programs that we may make available in connection with this contract. Such programs may include wellness programs, disease or care management programs, and other programs as found under the Health Management Programs Offered provision. *You* may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.NHhealthyfamilies.com or by contacting Customer Service by telephone at 1-844-265-1278 (TDD/TTY 1-855-742-0123). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by *us* through updates available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

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

For services or supplies that require *prior authorization 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. Receives a service or supply from a *network provider* to which *you* or *your dependent member* were referred by a *non-network provider.*

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

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

Prior Authorization requests shall be received by telephone, efax, or provider web 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 48 hours of any inpatient admission, including emergent inpatient admissions, or as reasonably practicable.
5. At least 5 days prior to the start of home healthcare except for *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 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.

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

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

Failure to Obtain *Prior Authorization*
Failure to comply with the prior *authorization* requirements will result in benefits being reduced. A reduction in benefits will be not more than 50% of the benefit that would have otherwise been payable or $1,000.00, whichever is less. Services rendered that fail to comply with prior authorization are subject to medical necessity review.

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

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

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

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. 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, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, *we* may provide a *prior authorization* for you to obtain the service from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or your *primary care provider* must

request *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, *you* will be responsible for all charges incurred.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses, fees, taxes, or surcharges imposed on *you* or *your* covered *dependent* 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; and*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*;
2. For any portion of the charges that are in excess of the *eligible 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 this *contract*;
4. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of gender dysphoria;
5. For the reversal of sterilization and the reversal of vasectomies;
6. For abortion unless *medically necessary* or the life of the mother would be endangered if the fetus were carried to term;
7. For artificial insemination (AI), assisted reproductive technology(ART) procedures or the diagnostic tests and drugs to support AI or ART procedures;
8. For expenses for television, telephone, or expenses for other persons;
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
10. For failure to keep a scheduled appointment;
11. For stand-by availability of a *medical practitioner* when no treatment is rendered;
12. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered *dependent* child that has resulted in a functional defect;

14. 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 provider 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 a parole or probation, unless a Plan provider determines such services to be *medically necessary*.
    c. court ordered testing and testing for ability, aptitude, intelligence or interest.

    **Services which are custodial or residential in nature.
    **Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
16. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
17. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *contract*;
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*;
19. 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;
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *contract*;
21. 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;
22. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 180 consecutive days;
23. 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 by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency**.** Coverage is provided under the contract when a member waives worker's compensation coverage in accordance with New Hampshire law;
24. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war; or
    b. The *member* taking part in a riot;

25. For or related to treatment of hyperhidrosis (excessive sweating);
26. For fetal reduction surgery;
27. Except as specifically identified as a *covered service expense* under the *contract*, 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;
28. Care or complications resulting from non-*covered service expenses,* except for services we would otherwise cover to treat complications from the non-covered service;
29. For the following miscellaneous items, unless specifically described in this *contract*: artificial Insemination except where required by federal or state law; biofeedback, chelating agents; domiciliary care; food and food supplements; 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; private duty nursing; 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;
30. Diagnostic testing , laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment;
31. Services or supplies eligible for payment under either Federal or State Programs (except Medicaid). This exclusion applies whether or not you assert your right to obtain this coverage or payment of the services;
32. *Surrogacy Arrangement.* Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insured's possessing an active policy with *us* and/or the child possesses an active policy with *us* at the time of birth.

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if *you* are enrolled through the Marketplace, the date of termination that the Marketplace provides *us* upon *your* request of cancellation to the Marketplace.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if *you* are the only *member* on this *contract*.
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 year in which the Dependent Child reaches the limiting age of 26.
6. The date *your* eligibility for coverage under this Contract ceases as determined by the Marketplace.

If there are other *members* covered under this *contract*, it may be continued after *your* death:

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

This *contract* will be changed and *your spouse* or youngest child will replace *you* as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on a pro-rata basis.

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The primary *member* residing outside the *Service Area* or moving permanently outside the *Service Area* of this plan;
3. The date of a *member's* death;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
6. 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.

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

age limit listed in the definition of *eligible child*.

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

1. 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 the primary *member* for support.

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

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

180-Day Notice:
If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside at the end of the plan year, *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.

Notification Requirements
It is the responsibility of *you* or *your* former *spouse* to notify the Marketplace or *us* within 31 days of *your* legal divorce.

REIMBURSEMENT

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

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *contract* benefits for the *member's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *member* subsequently receives payment for medical benefits incurred and paid from any *third party* or a limited percentage based on a comparative fault determination.

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

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*;
4. That *we*:
    a. May give notice of that lien to any *third party* or *third party's* agent or representative; and
    b. Will have the right to intervene in any suit or legal action to protect *our* rights.
5. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.

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

CLAIMS

Notice of Claim
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any *loss* covered by the *contract*, or as soon thereafter as is reasonably possible.

Notice given by or on behalf of the insured or the beneficiary should be sent to the insurer at Ambetter from NH Healthy Families, P.O. Box 25408 Little Rock, AR 72221, or to any *authorized* agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms
Upon receipt of a notice of claim, *we* will furnish to the *claimant* such forms as are usually furnished by *us* for filing *proofs of loss*. If such forms are not furnished within 15 days after the giving of such notice *you* shall be deemed to have complied with the requirements of this *contract* as to *proof of loss* upon submitting, within the time fixed in the *contract* for filing *proofs of loss*, written proof covering the occurrence, the character and the extent of the *loss* for which claim is made.

Proof of Loss
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* 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 *contract* and, as often as may be reasonably necessary:

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

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

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

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

Payment of Claims
Benefits are paid to or on behalf of the *member* within 30 days after receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

If Ambetter from NH Healthy Families is denying or pending the claim, Ambetter from NH Healthy Families shall have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the healthcare provider or *member* of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon Ambetter from NH Healthy Families receipt of the requested additional information, Ambetter from NH Healthy Families shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated. Should your claim be denied, in partial or in whole, we will, of course, be available to you to discuss the position we have taken. Should you, however, wish to take this matter up with the New Hampshire insurance department, it maintains a service division to investigate complaints at 21 South Fruit Street, Suite 14, Concord, New Hampshire 03301. The New Hampshire insurance department can be reached, toll-free, by dialing 1-800-852-3416.

Any claim not paid within the time periods specified shall be deemed overdue. When a claim is overdue, the healthcare provider may notify Ambetter from NH Healthy Families in writing of Ambetter from NH Healthy Families noncompliance. If *we* fail to pay the claim within the allotted time, then:

1. The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and
2. The healthcare provider may recover from Ambetter from NH Healthy Families, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a healthcare provider in a successful action against *us* for payment of the claim.

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 also include the applicable medical records in English to show proper *proof of loss* and evidence of payment to provider.

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

We will pay the benefits of this *contract* to the state if:

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

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

Insurance with Other Insurers
If there is other valid coverage, not with *us*, providing benefits for the same *loss* on a provision of service basis or an expense incurred basis, payment shall not be prorated or reduced. If such is the case, the *member* shall be entitled to payment from both insurers. Provided, however, that the provisions of this subparagraph shall not prohibit the issuance of a *benefits deductible*. *Benefits deductible*, as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other *hospital*, surgical or medical insurance *contract* or *hospital* or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis. Provided, however, that the term *benefits deductible* shall not mean the value of benefits provided with respect to medical or liability insurance offered under either a general liability insurance contract or an auto insurance contract.

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

Upon request by the custodial parent, *we* will:

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

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

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

Non-Assignment
The coverage, rights, privileges and benefits provided for under this policy are not assignable by *you* or anyone acting on *your* behalf. Any assignment or purported assignment of coverage, rights,

privileges and benefits provided for under this policy that you may provide or execute in favor of any *hospital*, provider, or any other person or entity shall be null and void and shall not impose any obligation on *us*.

Notwithstanding the foregoing, *you* may specifically authorize, in writing, the payment of benefits that we have determined to be due and payable directly to any *hospital*, provider, or other person who provided *you* with any covered service and *we* will honor this specific direction and make such payment directly to the designated provider of the covered service.

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

INTERNAL GRIEVANCE, INTERNAL APPEALS AND EXTERNAL REVIEW PROCEDURES

If *you* need help*:* If *you* do not understand *your* rights or if *you* need assistance understanding *your* rights or *you* do not understand some or all of the information in the following provisions, *you* may contact Ambetter from NH Healthy Families, *Member* Services Department, 2 Executive Park Drive, Bedford, NH, 03110, by telephone at 1-844-265-1278 (TDD/TTY 1-855-742-0123), or at Ambetter.NHhealthyfamilies.com

You will have up to one hundred and eighty days (180) days of the date *your* area of dissatisfaction occurred to file a grievance.

INTERNAL GRIEVANCE

Internal Grievance Procedures: When *you* are dissatisfied with the quality of service or the quality of care *you* have received from the Plan or from our contracted providers, *you* or someone *you* have *authorized* to speak for *you* on *your* behalf (*authorized* representative) can request a grievance regarding the:

- Availability, delivery, or quality of health care services, systems, and materials
- The interactions or relationship between *you* and Ambetter from NH Healthy Families
- Failure to respect *your* rights
- Our denial to process *your* request for appeal as an expedited internal first level appeal

You or *your authorized* representative may file the grievance in writing, either by mail or by facsimile (fax). If *you* require assistance in filing a grievance or if *you* are unable to submit the grievance in writing, *you* can call the Plan *Member* services to ask for help through the process.

Once *your* grievance is received, the health plan is required to acknowledge receipt of your request in 5 business days and is required to review and investigate *your* concerns. The Health Plan will notify *you* or *your authorized* representative of our resolution, which will include:

- the nature of the Grievance,
- the specific information reviewed/considered,
- the resolution,
- Standard criteria and/or clinical guidelines used in the basis for the decision,
- and *your* right to request an Internal Appeal, as appropriate.

We will give *you* an answer in writing as expeditiously as *your* health requires, not to exceed 72 hours from receipt of *your* clinically urgent grievance or within thirty (30) calendar days from receipt of *your* non-urgent grievance.

The Plan may extend the timeframe for disposition of a *grievance* for up to 14 calendar days if the *member* requests the extension or the Plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the *member's* interest. If the Plan extends the timeframe, it shall, for any extension not

requested by the *member*, give the member written notice of the reason for the delay. Plan will notify *member* of the grievance resolution in writing within two (2) business days of the resolution not to exceed the total resolution timeframe (i.e. 30 days). The notice of resolution shall include the results of the resolution process, detail to identify the *grievance* (provider, claim number, diagnosis, etc.), the date it was completed and further *appeal* rights, if any.

You, or *your authorized* representative, have the right to request a free copy of the documentation used in this decision. *You* can also ask to get copies, at no cost to *you*, of all the documents used to review *your* grievance.

There will be no retaliation of any sort against the *you*, *your authorized* representative, or *your provider* for filing a Grievance.

INTERNAL APPEALS

Internal Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service denial) or denies *your* request to *authorize* treatment or service (pre-service denial), *you*, or someone *you* have *authorized* to speak on *your* behalf (an *authorized* representative), can request an appeal of the plan's decision. The request must be made in writing within 180 days of the decision. An oral request can be initially made but must be followed up in writing. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your appeal*, it is required to review its own decision.

When the plan makes a claim or *authorization* request decision, it is required to notify *you* (provide notice of an *adverse benefit determination*):

- The reasons for the plan's decision;
- *Your* right to file an appeal regarding the adverse decision; and
- *Your* right to request an external review.

- The plan will acknowledge all oral or written *appeals* in writing within 5 business days of the receipt of a request for an *appeal*.
- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.
- When *you* request an internal appeal, the plan must give *you* its decision as soon as possible, but no later than:
    - 72 hours after receiving *your* request when *you* are appealing the denial of an *authorization* for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal expedited appeal and external reviews take place at the same time.)
    - 30 days for appeals of denials of non-urgent care *you* have not yet received.
    - 30 days for appeals of denials of services *you* have already received (post-service denials).
    - The Plan may extend the resolution notification time frame, for standard appeals, to 45 calendar days to obtain additional information only if:
        1. The information was not submitted with the original request and

2. The Plan requested the information within 24 hours for expedited appeals and within 5 business days for standard appeals.

Continuing Coverage*: The plan cannot terminate your benefits until all of the appeals have been exhausted.* **However, if the plan's decision is ultimately upheld, *you* may be responsible for paying any outstanding claims for services provided after receiving notification of the adverse Internal Appeal or External Appeal determination.** If an expedited review involves ongoing urgent care services, the service shall be continued without liability to the *member* until the *member* has been notified of the determination.

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

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

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

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

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

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

Time Limits for filing internal and external appeal: Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. Failure to file within this time limit may result in the company's declining to consider the appeal.

Time Limits for notification on an Internal Appeal determination: The plan will provide notification of the Internal Appeal determination within the following timeframes:

- 72 hours after receiving *your* request when *you* are appealing the denial of a request for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal

appeal and external reviews take place at the same time.)

- 30 days for appeals of denials of non-urgent care *you* have not yet received.
- 30 days for appeals of denials of services *you* have already received (post-service denials).
- No extensions of the above maximum time limits are permitted unless we notified *you* that the appeal request did not contain sufficient information in order to provide a determination. The extended time period will not exceed 45 days from the date we notified *you* of what information was required.

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

- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the appeal; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to give *you* a reasonable opportunity to respond prior to that date; and
- Before the plan can issue a *final internal adverse benefit determination* based on a new or additional rationale, *you* must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give *you* a reasonable opportunity to respond prior to that date.
- The adverse determination must be written in a manner understood by *you*, or if applicable, *your authorized* representative and must include all of the following:
    1. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
    2. Information sufficient to identify the appeal involved, including the date of service, the healthcare provider; and
    3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have sufficient information; such a decision; however, will allow *you* to advance to the next stage of the claims process.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this overview.

Non-urgent, pre-service appeal

For a non-urgent pre-service appeal, the plan will notify *you* of its decision as soon as possible but no later than 30 days after receipt of the appeal.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. *You* will have 45 days from the date of the plan's notice to provide the information. If *you* do not provide the additional information, the plan can deny *your* appeal. In which case, *you* may file an appeal.

The plan will provide notification of the determination within 30 days of receiving *your* request for appeal, unless the timeframe was extended because additional information was required. In such a

scenario, the plan will provide notification of the determination within 45 days of the date we notified *you* of what information is required.

Urgent Pre-service (Expedited) Appeal
If *your* appeal is urgent, *you* or *your authorized* representative, or *your* healthcare provider (*physician*) may contact us with the claim, orally or in writing.

If the appeal is one *involving urgent care*, we will notify *you* of our decision as soon as possible, but no later than 72 hours after we receive *your* appeal provided *you* have given us information sufficient to make a decision.

If *you* have not given us sufficient information, we will contact *you* as soon as possible but no more than 24 hours after we receive *your* appeal to let *you* know the specific information we will need to make a decision.

You must give us the specific information requested as soon as *you* can but no later than 48 hours after we have asked *you* for the information.

We will notify *you* of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours *you* had to provide the additional information.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly. We will provide written notification to *you* within two business days of providing notification of the decision, if the initial notification is not in writing.

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

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

The *physician*, if the *physician* certifies, in writing, that *you* has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an *adverse benefit determination* would seriously jeopardize *your* life or health or jeopardize *your* ability to regain maximum function, *you* may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal.

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

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

(2) After a final *adverse benefit determination*, if either of the followingapplies:

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

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

Concurrent care decisions

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

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

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

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

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

Post-service appeal of a claim denial (retrospective)

If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 30 days after we have received *your* appeal. If the reason we need more time to make a decision is because *you* have not given us necessary information, *you* will have 45 days from the date we notify *you* to give us the information. We will describe the information needed to make our decision in the notice we send *you*. This is also known as a "retrospective review." The plan will notify *you* of its determination as soon as possible but no later than 5 days after the benefit

determination is made.

The plan will let *you* know within 5 days of receipt of your request for appeal by requesting any additional information needed, and advising *you* when a final decision is expected. If more information is requested, *you* have at least 45 days to supply it. The appeal then must be decided no later than 15 days after *you* supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim, less any applicable cost-share, such as *copayments*, *coinsurance*, or *deductible*) before the end of the time allotted for the decision, which will not exceed 45 days from the date we notified *you* that we required additional information.

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.

Applicability/Eligibility
The External Review procedures apply to:

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

After exhausting the internal review process, the *claimant* has 180 days after the date of receipt of *our* internal response to make a written request to the New Hampshire Insurance Department for external review.

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 healthcare 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.

External review is available for *appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, healthcare 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.

Standard External Review Process

1. Within 7 business days after the date of receipt of a request for external review, the New Hampshire Insurance Commissioner ("Commissioner" shall complete a preliminary review of the request to determine whether:
    a. *You* are or were a *covered person* under the health benefit plan;
    b. The determination that is the subject of the request for external review meets the conditions of eligibility for external review; and
    c. The covered person has provided all the information and forms required by the commissioner that are necessary to process a request for an external review.
2. Upon completion of the preliminary review, the Commissioner shall immediately notify *you* or *your authorized* representative in writing:
    a. Whether the request is complete; and
    b. Whether the request has been accepted for external review.
3. If the request is not complete, the Commissioner shall inform *you* or *your authorized* representative what information or documents are needed to make the request complete and to process the request. *You* or *your authorized* representative must submit such information or documentation within 10 days of being notified that the request was incomplete.
4. If the request for external review is accepted, the Commissioner shall:
    a. Include in the notice provided to *you* a statement that if *you* wish to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, oral testimony shall be permitted only in cases when the Commissioner determines, based on evidence provided by *you*, that it would not be feasible or appropriate to present only written testimony.
    b. Immediately notify *us* in writing of the request for external review and its acceptance.
5. If the request for external review is not accepted, the Commissioner shall inform *you* or *your authorized* representative and *us* in writing of the reason for its non-acceptance.
6. At the time a request for external review is accepted, the Commissioner shall select and retain an independent review organization that is certified to conduct the external review.
7. Within 10 days after the date of issuance of the notice provided, *we* shall provide to the selected independent review organization and to *you* all information in our possession that is relevant to the adjudication of the matter in dispute.
8. The selected independent review organization will review all of the information and documents received from *us* and any other information submitted by *you* or *your authorized*

representative or treating provider with the request for external review and any testimony provided.

9. The selected independent review organization shall render a decision upholding or reversing the *adverse determination* and notify *you* or *your authorized* representative in writing within 20 days of the date that any new or additional information from the covered person is due.

Expedited External Review Process

1. Expedited external review shall be available when the *your* treating healthcare provider certifies to the Commissioner that adherence to the time frames for Standard External Review would seriously jeopardize the life or health of *you* or would jeopardize *your* ability to regain maximum function.
2. At the time the Commissioner receives a request for an expedited external review, the Commissioner shall immediately make a determination whether the request meets the standard for expedited external review. If these conditions are met, the Commissioner shall immediately notify the *us*. If the request is not complete, the Commissioner shall immediately contact *you* or *your authorized* representative and attempt to obtain the information or documents that are needed to make the request complete.
3. The Commissioner shall select and retain an independent review organization that is certified to conduct the expedited external review.
4. When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify *you* as expeditiously as *your* medical condition requires, but in no event more than 72 hours after the expedited external review is requested.
5. If the notice provided pursuant to paragraph IV was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall provide written confirmation of the decision to *you* or *your authorized* representative.
6. All requirements for Standard External Review apply to Expedited External Review.

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*. The eligible grievant/*claimant* may file a request for an external review with the New Hampshire Department of Insurance at 21 South Fruit Street, Suite 14, Concord, NH 03301 or at 603-271-2261.

Assistance can also be received by contacting the New Hampshire Department of Insurance. Additionally, included as an attachment to this contract is the New Hampshire Department of Insurance's "Managed Care Consumer Guide to External Appeal."

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

Definitions
For the purpose of the Section, the following definitions shall apply:
A **Plan** is any of the following that provides benefits or services for medical care or treatment. A plan includes group, individual or blanket disability insurance contracts, and group or individual contracts issued by healthcare service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have healthcare coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. If this Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit.

Allowable Expense except as outlined below is a healthcare expense, including Deductibles, Coinsurance and Copayments, and without reduction for any applicable Deductible, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. When coordinating benefits, any Secondary Plans must pay an amount which, together with the payment made by the Primary Plan, cannot be less than the same allowable expense as the Secondary Plan would have paid if it was the Primary Plan. In no event will a Secondary Plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

1. If you advise us that all plans covering you are high-deductible health plans and you intend to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's Deductible will not be considered an allowable expense, except for any healthcare expense incurred that may not be subject to the Deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense that is not covered by any Plan covering you is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by two or more Plans that compute their benefit payments on the basis of

usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

Closed Panel Plan is a Plan that provides healthcare benefits to you in the form of services through a panel of Providers who are primarily employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel Member.

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

Order of Benefit Determination Rules
When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. A plan that does not contain a coordination of benefits provision that is consistent with This Plan's rules is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the Contract holder. Examples include major medical coverage that are superimposed over Hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent
The plan that covers you other than as a dependent, (for example as an employee, Member, Contract holder, subscriber or retiree) is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan. However, if you are a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1. Secondary to the plan covering you as a dependent; and
2. Primary to the plan covering you as other than a dependent (e.g. a retired employee).

Then the order of benefits is reversed so that the plan covering you as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering you as a dependent is the primary plan.

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

1. For a child whose parents are married or are living together, whether or not they have ever been married:
    a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    a. If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, then that parent's spouse's plan is the primary plan. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
    b. If a court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
    c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
    d. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
        i. The Plan covering the Custodial Parent, first;
        ii. The Plan covering the Spouse of the Custodial Parent, second;
        iii. The Plan covering the non-custodial parent, third; and then
        iv. The Plan covering the Spouse of the non-custodial parent, last.
3. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

Longer or Shorter Length of Coverage

1. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.
2. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.
3. The start of a new plan does not include:
    a. A change in the amount or scope of a plan's benefits;
    b. A change in the entity that pays, provides or administers the plan's benefits; or
    c. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan; and
4. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force; and,

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

Effect on the Benefits of This Plan
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100% of the total Allowable Expense for the claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

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

Facility of Payment
If payments that should have been paid by us are paid by another plan, we have the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid by us. To the extent of such payments, we are fully discharged from liability under this plan.

Right of Recovery
We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans. If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your Network Provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

Effect of Medicare
Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. When Medicare Part B is primary, Medicare's allowable amount is the highest allowable expense.

When we render care to a person who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, we will seek Medicare reimbursement for all Medicare Covered Services.

CAUTION: All health plans have timely claim filing requirements. If you or your Provider fail(s) to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your Provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your Providers and plans any changes in your coverage. If you are covered by more than one health benefit plan, you should file all your claims with each plan.

GENERAL PROVISIONS

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

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

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

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the insurance 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 insured under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* paid during the time the *member* was insured under the *contract*.

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

Time Limit on Certain Defenses:
After 2 years from the date of issue of this *contract* no misstatements, except fraudulent misstatements, made by *you* in the application for such contract shall be used to void the *contract* or to deny a claim for loss incurred commencing after the expiration of such 2-year period. We will send a 30 day advance notice in the event such a defense is used.

PATIENT'S BILL OF RIGHTS

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for *emergency* admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider'' means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a *physician*, *hospital* or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are *authorized* in writing by a *physician* for a specific and limited time necessary to protect the patient or others from injury. In an *emergency*, restraints may be *authorized* by the designated professional staff *member* in order to protect the patient or others from injury. The staff *member* must promptly report such action to the *physician* and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise *authorized* by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a *physician*. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.

XVII. The patient shall be entitled to be treated by the patient's *physician* of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered *terminally ill* by the *physician* responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de NH Healthy Families, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-265-1278 (TTY/TDD 1-855-742-0123).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from NH Healthy Families, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from NH Healthy Families 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 1-844-265-1278 (TTY/TDD 1-855-742-0123)。
Nepali:	यदि तपाईं वा तपाईंले मद्दत गरिरहनुभएको कोही व्यक्तिसँग Ambetter from NH Healthy Families सम्बन्धी कुनै प्रश्नहरू भएको खण्डमा तपाईंहरूसँग आफ्नै भाषामा निःशुल्क मद्दत र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्नका लागि 1-844-265-1278 (TTY/TDD 1-855-742-0123) नम्बरमा कल गर्नुहोस्।
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from NH Healthy Families, 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 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from NH Healthy Families, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from NH Healthy Families, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from NH Healthy Families، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from NH Healthy Families, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Indonesian:	Jika Anda, atau orang yang Anda bantu, memiliki pertanyaan tentang Ambetter from NH Healthy Families, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan juru bicara, hubungi 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from NH Healthy Families 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-265-1278 (TTY/TDD 1-855-742-0123) 로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from NH Healthy Families вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-265-1278 (TTY/TDD 1-855-742-0123).
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from NH Healthy Families, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Bantu:	Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from NH Healthy Families, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from NH Healthy Families, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-844-265-1278 (TTY/TDD 1-855-742-0123).

Statement of Non-Discrimination

Ambetter from NH Healthy Families 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 NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from NH Healthy Families:

- 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 NH Healthy Families at 1-844-265-1278 (TTY/TDD 1-855-742-0123).

If *you* believe that Ambetter from NH Healthy Families 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: NH Healthy Families Appeal Department, 2 Executive Park Drive, Bedford, NH 03110, 1-844-265-1278 (TTY/TDD 1-855-742-0123), Fax 1-877-502-7255. *You* can file a grievance by mail, fax, or email. If *you* need help filing a grievance, Ambetter from NH Healthy Families 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*.

Ambetter from NH Healthy Families is underwritten by Celtic Insurance Company.