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# 2023 Ambetter Evidence of Coverage

Ambetter.WesternSkyCommunityCare.com

# IMPORTANT NOTICE

1. *Cost sharing* and benefit *limitation*s for an *emergency* health care service rendered by a *non-participating provider* shall be the same as if rendered by a *participating provider*. *Prior authorization* shall not be required for *emergency* health care services.
2. *Cost sharing* and benefits *limitation*s for a *medically necessary*, non-emergent health care service rendered by a *non-participating provider* at a *participating facility* where the *member* had no ability or opportunity to choose to receive the service from a *participating provider* shall be the same as if the service was rendered by a *participating provider*.
3. *Cost sharing* and benefits *limitation*s for a *medically necessary*, non-emergent health care service where no *participating provider* is available to render the service shall be the same as if the service was rendered by a *participating provider*.

# Ambetter from Western Sky Community Care, Inc.

Home Office: 5300 Homestead Road NE, Albuquerque, NM 87110

Major Medical Expense Insurance Policy

In this *policy,* the terms "you", or "your", will refer to the *member* or any *dependents* named in the enrollment application. The terms "we," "our," or "us" will refer to Western Sky Community Care, Inc.

## AGREEMENT AND CONSIDERATION

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

## GUARANTEED RENEWABLE

Guaranteed renewable means that this *policy* will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* in force by timely payment of the required premiums. However, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

Annually, we may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a *calendar year*.

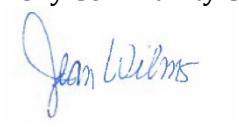
At least 60 *days'* notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all polices issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 *days* prior to the date that we discontinue coverage.

**This *policy* contains *prior authorization* requirements.** You **may be required to obtain a referral from a *primary care practitioner (PCP)* in order to receive care from a *specialist provider*. Failure to comply with the *prior authorization* requirements may result in denial of payment. Please refer to the *Summary of Benefits and Coverage (SBC)* and the Prior Authorization section.**

## TEN DAY RIGHT TO RETURN POLICY

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

Western Sky Community Care, Inc.



Jean D. Wilms
CEO and Plan President

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# Introduction

Welcome to Ambetter from Western Sky Community Care! This *policy* has been prepared by us to help explain your coverage. Please refer to this *policy* whenever you require medical services.

It describes:

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

This *policy*, the *Summary of Benefits and Coverage (SBC)*, the application as submitted to the New Mexico Health Insurance Exchange (Exchange), and any amendments and/or riders (if applicable) attached shall constitute the entire *policy* under which *covered services* and supplies are provided or paid for by us.

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

**How to Contact Us**

Ambetter from Western Sky Community Care, Inc.
5300 Homestead Road NE
Albuquerque, NM 87110

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

| | |
|---|---|
| Member Services | **1-833-945-2029** |
| TTY line | **711** |
| Fax | **1-833-751-0895** |
| Emergency | **911** |

24/7 Nurse Advice Line **1-833-945-2029** or for the hard of hearing (TTY 711)

**Interpreter Services**

We have 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 representatives that speak Spanish and medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpreter services, please call Member Services at 1-833-945-2029 or for the hard of hearing (TTY 711).

# Member Rights and Responsibilities

We are committed to:

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

If you have difficulty locating a *primary care practitioner (PCP)*, *specialist physician*, *hospital* or other contracted *provider* please contact us so that we can assist you with accessing or in locating a *provider* who contracts with us. *Physicians* within our *network* may be affiliated with different *hospitals*. Our online directory can provide you with information *for* the *hospitals* that are contracted with us. The online directory also lists affiliations that your *provider* may have with non-contracted *hospitals*. Your coverage requires you to use contracted *providers* with limited *exceptions*. You can access the online directory at Ambetter.WesternSkyCommunityCare.com.

Ambetter from Western Sky Community Care holds a Member Advisory Group (MAG) quarterly. At these meetings, we give *members* like you the chance to share your thoughts and ideas with us, talk about the services and tell us how we are doing. In addition, you will have the chance to ask questions or share any concerns. Contact Member Services or Email: wscccommunity@westernskycommunitycare.com if you are interested in participating.

You have the right to:

1. Participate with your *physician* and *medical practitioners* in making decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized representative. You will be informed of your care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Have services available and accessible when *medically necessary*.
5. Have access to urgent and *emergency care* services 24 hours per *day*, seven *days* per week, and for other health care services as defined by the *policy*.
6. Be treated with courtesy and consideration, and with respect for the *covered person*'s dignity and need for privacy.
7. Be provided with information concerning our policies and procedures regarding products, services, *providers*, and *appeals* procedures and other information about the company and the benefits provided.
8. Privacy of your personal health information, consistent with state and federal laws, and our policies.
9. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians, medical practitioners*, *hospitals* and other facilities and your rights and responsibilities.
10. 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 *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the *policy*, 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 representative. Your *physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.

11. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
12. See your *medical records*.
13. Be kept informed of *covered* and non-covered services, program changes, how to access services, *PCP* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 *days* before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
14. Receive prompt notification in writing of termination or changes in benefits, services or *provider network*.
15. A current list of *participating providers*.
16. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
17. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability or expected health or genetic status.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
19. Access and correct any and all *confidential abuse information* that we may have concerning you in compliance with the New Mexico Domestic Abuse Act.
20. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your *provider*(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *physician's* instructions are not followed. You should discuss all concerns about treatment with your *physician*. Your *physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
21. A complete explanation of why care is denied.
22. An opportunity to *appeal* the denial decision to us, the right to a secondary *appeal*, and the right to request the superintendent's assistance.
23. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *participating providers* close to your home or work.
24. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
25. An interpreter when you do not speak or understand the language of the area.
26. A *second opinion* by a *network physician* if you want more information about your treatment.
27. Make advance directives for health care decisions. This includes planning treatment before you need it.
28. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing Advanced directive forms. Advance directives forms are forms you can complete to protect your rights for medical care. It can help your *PCP* and other *providers* understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.
29. Receive premium and claim data within sixty days of receipt of a written request. Ambetter will provide premium data and redirect you to BeWellNM (Exchange) for any detailed premium data to include the sum of all premiums charged or billed for the insurance policy. The claims data will include the sum of all amounts paid out pursuant to claims covered under the policy; a list of all pending claims against the policy which are open; and cumulative loss or claim reserves chargeable to the policy.

You have the responsibility to:

1. Read this *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. 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 *member* identification 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 *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting r Member Services.
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. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* 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.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
13. Pay your monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *coinsurance amounts* on time.
14. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *policy* within 60 *days* of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where *member cost share* would need to transfer from one policy to another policy.

# Important Information

**Provider Directory**

A listing of *participating providers* is available online at Ambetter.WesternSkyCommunityCare.com. We have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you with your health care services. You may find our *participating providers* by accessing our website at Ambetter.WesternSkyCommunityCare.com/findadoc. From the home page, choose one of the available search options. Enter "New Mexico" as your home state and the applicable coverage year. Click on "continue". The applicable network, Bronze|Silver|Gold NM will be selected by default. Finally, click on "Start browsing," from there you will have the ability to narrow your search by *provider* specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of *providers* based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, you can request a copy of the Provider Directory at no charge by calling Member Services at 1-833-945-2029 (TTY 711). On a bi-annual basis, we will provide notice to you of any deletions or additions to the list of *participating providers* in our Provider Directory. In order to obtain benefits, you must designate a *network primary care practitioner (PCP)* for each *member.* We can also help you pick a *PCP*. We can make your choice of *PCP* effective on the next *business day*.

Call the *PCP's* office if you want to make an appointment. If you need help, call Member Services at 1-833-945-2029 (TTY 711). We will help you make the appointment.

**Member Identification Card**

We will mail you a *member* identification card after our receipt of your completed enrollment materials and you have paid your initial premium payment. This card is proof that you are enrolled in the Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *policy*.

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services at 1-833-945-2029 (TTY 711). We will send you another card. A temporary identification card can be downloaded from Ambetter.WesternSkyCommunityCare.com.

**Website**

Our website helps you get the answers to 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.WesternSkyCommunityCare.com. It also gives you information on your benefits and services such as:

1. Finding a *network provider*, including *hospitals* and pharmacies.
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* identification card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our Formulary or Preferred Drug List.
8. *Deductible amount* and *copayment amount* accumulators.
9. Selecting a *primary care physician*.

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact the New Mexico Health Insurance Exchange at https://www.bewellnm.com/ or 1-833-862-3935.

**Quality Improvement**
We are committed to providing quality health care 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 National Academy of Medicine (NAM) priorities. To help promote safe, reliable, and quality health care, 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 health care and specific diseases.
3. Sending reminders to *members* to get annual tests such as a physical examination, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee which includes *participating 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 Member Services.

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 health care and services you are receiving.

**Protection from Balance Billing**
Under Federal law, effective January 1, 2022, *non-participating providers* or facilities are prohibited from *balance billing* health plan *members* for:

1. *Emergency services* provided to a *member*, regardless of plan participation; or
2. Non-emergency health care services provided to a *member* at a participating *hospital* or at a participating health care *facility* if the *member* did not give informed consent or receive *prior authorization* to be seen by the *non-participating provider* pursuant to the federal No Surprises Act.

Please review the Access to Care and Major Medical Expense Benefits sections of this *policy* for detailed information.

# Definitions

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

Wherever used in this *policy*:

***Acquired brain injury*** means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The *injury* to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

***Acute rehabilitation*** means *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally received 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 *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

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

***Administrative grievance*** means an oral or written *complaint* submitted by or on behalf of a *covered person* regarding any aspect of health benefits plan other than a request for health care services, including but not limited to:

1. Administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services;
2. Claims payment, handling, or reimbursement for health care services; and
3. Termination of coverage.

***Adverse benefit determination*** means an oral or written *complaint* submitted by or on behalf of a *covered person* regarding an *adverse determination*.

Refer to the Summary of Health Insurance Grievance Procedures section of this *policy* for information on your right to *appeal* an *adverse benefit determination.*

***Adverse determination*** means a decision made either pre-service or post-service, by a health care insurer that a health care service requested by a *provider* or *covered person* has been reviewed and, based upon the information available, does not meet the health care insurer's requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated.

***Allowed amount*** (also see ***Eligible expense***) means the maximum portion of a billed charge that a health insurance carrier will pay, including any applicable *covered person cost sharing* responsibility, for a covered health care service or item rendered by a *participating provider* or by a *non-participating provider*.

**Note:** If you receive services from a *non-participating 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. However, you will not be responsible for *balance billing* for unanticipated non-network care that is otherwise covered under your

plan and that is provided by *a non-participating provider* at a *network facility*, unless you gave informed consent before receiving the services. You also will not be responsible for *balance billing* by a *non-participating provider* or *non-participating facility* for *emergency services* or air *ambulance services*. See *Balance Billing* and *Non-Participating Provider* definitions for additional information. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

***Ambetter Telehealth*** means the preferred vendor who we have contracted with to provide *telehealth* services to *members*. Our preferred vendor contracts with *providers* to render *telehealth* services to *members*. These services can be accessed via Ambetter.WesternSkyCommunityCare.com.

***Ambulance services*** means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

***Ambulatory surgical center*** means a *facility* where health care *providers* perform surgeries, including diagnostic and preventive surgeries that do not require *hospital* admission.

***Appeal*** means a request to reconsider a decision about the *member's* benefits where either a service or claims has been denied.

***Applied behavior analysis*** or ***ABA*** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

***Autism spectrum disorder*** means a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It is a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. It may include intellectual impairment but not always. The disorder may include problems with the ability to recognize or share interests or emotional experiences, problems expressing or understanding verbal or non-verbal communication, and/or developing or maintaining relationships. Repetitive patterns of behavior or an inability to tolerate change is often seen.

***Balance billing*** means a *non-participating provider's* practice of issuing a bill to a *covered person* for the difference between the *non-participating provider's* billed charges on a claim and any amount paid by the health insurance carrier as reimbursement for that claim, excluding any *cost sharing* amount due from the *covered person.*

***Behavioral health*** means both mental health and *substance use disorders*, encompassing a continuum of prevention, intervention, treatment and recovery support services.

***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*** means the amount a *provider* charges for a service.

***Business day*** means a consecutive 24-hour period, excluding weekends or state holidays.

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

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

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

***Center of Excellence*** means a *hospital* that:

1. Specializes in a specific type or types of *medically necessary* 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 *participating provider* does not mean it is a *Center of Excellence.*

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

***Coinsurance amount*** means a *cost sharing* method that requires a *covered person* to pay a stated percentage of medical or pharmaceutical expenses after the *deductible amount*, if any, is paid; *coinsurance amounts* may differ for different types of services under the same health benefits plan.

***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 *complications of pregnancy*.
2. An *emergency* cesarean section or a *non-elective cesarean section*.

***Confidential abuse information*** means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship.

***Copay, copayment*** or ***copayment amount*** means a *cost sharing* method that requires a *covered person* to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the health insurance carrier paying the allowed balance; there may be different *copayment amounts* for different types of services under the same health benefits plan.

***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 *illness*, *injury*, or congenital anomaly.

***Cost share*** or ***cost sharing*** means a *deductible amount*, *copayment amount, coinsurance amount* or any other form of financial obligation of a *covered person* other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the health benefits plan.

***Cost sharing reductions*** means the reduction in the amount you have to pay in deductibles, copayments, and coinsurance. To qualify for cost sharing reductions, an eligible individual must enroll in a silver level plan through the Exchange. State out-of-pocket assistance is also available for certain individuals in silver and gold plans. Members of a federally recognized American Indian tribe and/or an Alaska Native may qualify for additional cost sharing reductions.

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

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

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

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

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

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

***Day*** or ***days*** shall be interpreted as follows, unless otherwise specified:

(a) One to five *days* means only working *days* and excludes weekend and state holidays; and
(b) Six or more *days* means calendar *days*, including weekends and state holidays.

***Deductible*** or ***deductible amount*** means a fixed dollar amount that a *covered person* may be required to pay during a benefit period before the health insurance carrier begins payment for *covered services*; health benefit plans may have both individual and family *deductibles* and separate *deductibles* for specific services.

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 their *deductible amount* until the family *deductible amount* is satisfied for the *calendar year*.

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

***Dependent member*** means any *member* of your family who meets the requirements of this *policy*, who is enrolled as our *member*, and for whom we have received an application and the payment. Please reference the Dependent Member Coverage section of this *policy* for additional information.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with you for adoption;
4. A foster child placed in your custody;
5. A child for whom legal guardianship has been awarded to you, your *spouse* or domestic partner; or
6. A stepchild.

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

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

1. For *participating providers*: When a *covered service* is received from a *participating provider*, the *eligible expense* is the contracted fee with that *provider*.
2. For *non-participating providers*, unless otherwise required by New Mexico law, the *eligible expense* is as follows:
    a. When a *covered emergency service* is received from a *non-participating provider* within New Mexico, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. However, if the *provider* has not agreed to accept a negotiated fee with us as payment in full, the *eligible expense* is the *surprise bill reimbursement rate*. The *surprise bill reimbursement rate* shall be calculated using claims data reflecting the *allowed amounts* paid for claims in the 2017 plan year. You should not be *balance billed* for the difference between the amount we pay and the *provider's* charges, but you may be subject to *cost sharing* obligations. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
    b. When a covered *emergency service* is received from a *non-participating provider* outside of New Mexico, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* is reimbursement as determined by us and as required by applicable law. *Member cost share* will be calculated from the recognized amount based upon federal law. You should not be balance billed for the difference between the amount we pay and the *provider's* charges, but you may be subject to *cost-sharing* obligations. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

c. When a *covered* air *ambulance service* is received from a non-network *provider*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* is reimbursement as determined by us and as required by applicable law. *Member cost share* will be calculated from the recognized amount based upon applicable law. You should not be *balance billed* for the difference between the amount we pay and the provider*'s* charges, but you may be subject to *cost sharing* obligations. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
d. When a *covered emergency service* is received from a *non-participating* ground ambulance *provider*, the *eligible expense* is the negotiated fee, if any, that the *provider* has agreed to accept as payment in full. If there is no negotiated fee agreed to by the *provider* with us, the *eligible expense* is the usual, customary and reasonable rate. You should not be *balance billed* by the *provider*, if you are, please contact Member Services.
e. When a *covered service* is received from a *non-participating* professional provider who renders non-emergency services at a *network facility*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* is the *surprise bill reimbursement rate*. The *surprise bill reimbursement rate* shall be calculated using claims data reflecting the *allowed amounts* paid for claims in the 2017 plan year. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you should not be *balance billed* for the difference between the amount we pay and the *provider's* charges, but you may be subject to *cost sharing* obligations. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
f. When a covered air *ambulance service* is received from a non-network *provider*, the eligible service expense is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the eligible service expense is reimbursement as determined by us and as required by applicable law. *Member cost share* will be calculated from the recognized amount based upon applicable law. You should not be balance billed for the difference between the amount we pay and the *provider's* charges, but you may be subject to *cost sharing* obligations. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
g. When a *covered service* is received from a *non-participating provider* because the service or supply is not available from any *participating provider* in your *service area* and is not the result of an *emergency*, the *eligible expense* is the negotiated fee, if any, that the provider has agreed to accept as payment in full. If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is the usual, customary and reasonable rate. You should not be balance billed by the provider, if you are, please contact Member Services.
h. For all other *covered services* received from a *non-participating provider* for which any needed *authorization* is received from us, 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 should 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 greatest of the following: (1) the amount that would be paid under *Medicare*, (2) the amount for the *covered service* calculated using the same method we generally use to determine payments for non-network *providers*; or (3) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. You should not be balance billed by the provider, if you are, please contact Member Services.

*Surprise bill reimbursement rate*, as used in this section, means the sixtieth percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a state required benchmarking database; provided that no *surprise bill reimbursement rate* shall be paid at less than one hundred fifty percent of the 2017 *Medicare* reimbursement rate for the applicable health care service provided.

Usual, customary and reasonable rate, as used in this section, means health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area.

***Emergency services*** (medical, *Behavioral Health*, and *substance use disorder*) means covered *inpatient* and *outpatient services*, procedures or treatments to a *covered person* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or *stabilize* an *emergency* medical/*behavioral health* condition. An *emergency* medical/*behavioral health* medical condition manifests itself by symptoms of sufficient severity (including severe pain) that a reasonable layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following, regardless of eventual diagnosis:

1. Placing the physical or *behavioral health* of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Disfigurement to a person.

Services you receive from a *non-participating provider* or *non-participating facility* after the point your emergency medical/*behavioral health* condition is *stabilized* continue to meet the definition of *emergency services* until (1) you are discharged from the *facility*, or (2) both of the following circumstances are met, as well as any other criteria required by federal or state law: (a) the provider or *facility* determines you are able to travel using nonmedical transportation or nonemergency medical transportation, and (b) your provider obtains informed consent to provide the additional services.

***Follow-up care is not considered* emergency care.** Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency care* include *facility* costs and *physician* services, and supplies and *prescription drugs* charged by that *facility*. If you are admitted into the *hospital*, we require notification of your *hospital* admission. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *policy*. If your provider does not contract with us, you will be financially responsible for any care we determine is not *medically necessary*. Care and treatment provided once you are *medically stabilized* is no longer considered *emergency care*. Continuation of care from a *non-participating provider* beyond what needed to evaluate or *stabilize* your condition in an *emergency* will be covered as a non-network service unless we *authorize* the continuation of care and it is *medically necessary*.

***Emergency care*** means health care procedures, treatments or services delivered to a *covered person* after the sudden onset of what reasonably appears to be a medical or *behavioral health* condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person.

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

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

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

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

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

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

1. Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

*Extended care facility* does not include a *facility* primarily for rest, the aged, treatment of *substance use disorder, custodial care,* nursing care, or for care of *mental health disorders* or the mentally disabled.

***Facility*** means an entity providing health care service, including:

a. A general, specialized, psychiatric or *rehabilitation hospital*;
b. An *ambulatory surgical center*;

c. A cancer treatment center;
d. A birth center;
e. An impatient, outpatient or residential drug and alcohol treatment center;
f. A laboratory, diagnostic or other outpatient medical evaluation or testing center;
g. A health care *provider's* office or clinic;
h. An *urgent care center*; or
i. Any other therapeutic health care setting.

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

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

***Grievance*** means an oral or written *complaint* submitted by or on behalf of a *covered person* regarding either an *adverse determination* or an administrative decision.

***Habilitation*** or ***habilitation services*** means health care services that helps a patient keep, learn or improve skills and functioning for daily living. These services may be performed in an *inpatient* or outpatient setting and include: physical therapy, occupational therapy and speech therapy.

***Health maintenance organization (HMO)*** means a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally would not cover non-network care exempt in an *emergency*. An HMO may require you to live or work in its *service area* to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

***Health management*** means a program designed specially to assist you in managing a specific or chronic health condition.

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

***Home health care*** means care or treatment of an *illness* or *injury* at the *member's* home that is:
1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

***Home health care agency*** means a public or private agency, or one of its subdivisions, that:
1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily *medical record* on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing *generally accepted standards of medical practice* for the *illness* or *injury* requiring the *home health care.*

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

***Hospice*** means services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by a *network physician*. We work 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*.

***Hospital*** means a *facility* offering impatient services, nursing and overnight care for three or more individuals on a 24-hours-per-*day*, seven-*days*-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

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

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

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

***Inpatient*** means that services, supplies, or treatment for medical, *behavioral health*, or *substance use disorder* 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 unit or area of a *hospital* that meets the required standards of the Joint Commission on Accreditation of *Hospitals* for Special Care Units.

***Limitation*** means any provision that restricts coverage under a health benefit plan other than an *exception*, *exclusion* or *reduction*.

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

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

***Maximum out-of-pocket amount*** means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance amount* of covered expenses, as shown in the *Summary of Benefits and Coverage (SBC)*.

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

***Medical practitioner*** includes but is not limited to a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

***Medical record*** means all information maintained by a provider relating to the past, present or future physical or *behavioral health* of a patient, and for other provision of health care services to a patient. This information includes, but is not limited to the *provider's* notes, reports and summaries, and x-rays, laboratory, and other diagnostic test results. A patient's complete *medical record* includes information generated and maintained by the provider, as well as other information provided to the provider by the patient, by any other provider who has consulted with or treated the patient in connection with the provision of health care services to the patient. A *medical record* does not include the patient's medical billing or health insurance records or forms or communications related thereto.

***Medically necessary*** means health care services determined by a provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

a. any applicable generally accepted principles and practices of good medical care;
b. practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
c. any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or *behavioral health* condition, *illness*, *injury* or disease.

***Medically stabilized*** means that the person is no longer experiencing further deterioration as a result of a prior *illness* or *injury* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

***Medicare*** means Title 18 of the Social Security Amendments of 1965, "Health Insurance for Aged and Disabled," as then constituted or later amended.

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

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

***Member*** means an individual covered by the health plan including an enrollee, *subscriber* or policyholder. A *member* must either be named in the enrollment application or we must agree in writing to add them as a *dependent member*.

***Mental health disorder*** means a condition that causes disturbance in behavior, emotion and cognition. These disorders can vary in impact, ranging from no impairment to mild, moderate or severe impairment. Depending on the severity, they may be accompanied by significant distress that affects an individual's work, school and social relationships. *Mental health disorder* benefits are defined as benefits for items or services for mental health conditions listed in ICD-10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

***Minimum essential coverage*** means any health insurance plan that meets the Affordable Care Act (ACA) requirement(s) for health insurance coverage. Examples include, job-based plans, Health Insurance Marketplace ("Marketplace") plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

***Necessary medical supplies*** mean medical supplies that are:

1. Necessary to the care or treatment of an *illness* or *injury*;
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 *providers* or facilities (including, but not limited to *hospitals*, *inpatient* mental health care facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with us, or our contractor or subcontractor, and have agreed to provide health care services to our *members* for an agreed upon fee. *Members* will receive most if not all of their health care services by accessing the *network*.

***Network eligible expense*** means the *eligible expense* for services or supplies that are provided by a *participating 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-participating provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a *non-participating provider*.

***Non-elective cesarean section*** means:

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

***Non-participating provider*** means a provider who is not a *participating provider* as defined. Also known as a non-network provider or non-contracted provider.

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

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

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

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

***Participating provider*** means a provider who, under an express contract with a health insurance carrier or with its contractor or subcontractor, has agreed to provide health care services to *covered persons* with an expectation of receiving payment directly or indirectly from the carrier, subject to any *cost sharing* required by the health benefits plan. Also known as *network provider* or contracted provider.

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

***Policy*** means this *policy* issued and delivered to you. It includes the attached pages, the *Summary of Benefits and Coverage,* the applications, and any amendments or riders.

***Practitioner of the healing arts*** means a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, *injury*, disease, deformity or physical or mental condition pursuant to:

1. the Chiropractic *Physician* Practice Act
2. the Dental Health Care Act
3. the Medical Practice Act
4. Chapter 61, Article 10 NMSA 1978; and
5. The Acupuncture and Oriental Medicine Practice Act

**Note:** *Practitioner of the healing arts* could be a *PCP.*

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

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

***Prescription drug deductible amount*** means the amount of covered expenses, shown in the *Summary of Benefits and Coverage (SBC)*, 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.

***Preventive care*** means health care services provided for prevention and early detection of disease, *illness*, *injury* or other health condition.

***Primary care practitioner* (*PCP*)** means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to *covered persons*; who initiates the patient's referral for *specialist* care and who maintains continuity of patient care. *PCPs* include general practitioners, family practice *physicians*, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other health care professionals (such as *practitioner of the healing arts*) may also serve as *PCPs*.

***Prior authorization*** means a pre-service determination made by a health insurance carrier regarding a *covered person's* eligibility for health care services based on medical necessity, health benefits coverage and the appropriateness and a site of services pursuant to the terms of the health benefits plan.

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

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

***Provider*** means a licensed health care professional, *hospital* or other *facility authorized* to furnish health care services.

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

***Qualified health plan*** or ***QHP*** means a health plan that has in effect a certification from the superintendent that it meets the standards set forth in applicable federal and state law and regulations and rules as well as any additional requirements established by the board.

***Qualified individual*** means, an individual who has been determined eligible to enroll through the Exchange in a *qualified health plan* in the individual market.

***Reconstructive surgery*** means *surgery* from which an improvement in physiological function could reasonably be expected, when ordered by a *member's PCP* or treating health care professional and performed for the correction of functional disorders resulting from accidental *injury* or from congenital defects or disease or surgeries or other *medically necessary* health care services related to gender affirming care and the treatment of gender dysphoria.

***Rehabilitation*** means health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical or occupational therapy, speech-language pathology, respiratory, cardiac therapy and psychiatric *rehabilitation* services in a variety of *inpatient* and/or outpatient settings.

***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 disabled.

***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 therapy to help a person regain abilities that have been lost or impaired as a result of disease, *injury* or treatment. It is provided to optimize functioning and reduce disability in individuals. Types of *rehabilitation therapy* include: physical therapy, occupational therapy, speech therapy, cardiac therapy and respiratory therapy. It may occur in either an *inpatient* or outpatient setting.

***Rescission*** of a *policy* means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a *rescission* if: the cancellation or discontinuance of *coverage* has only a prospective effect; or the cancellation or discontinuance of *coverage* is effectively retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of *coverage*.

***Residence*** means the physical location where you live. If you live in more than one location, and you file a United States income tax return, the physical address (not a P.O. Box) shown on your United States income tax return as

your *residence* will be deemed to be your place of *residence*. If you do not file a United States income tax return, the *residence* where you spend the greatest amount of time will be deemed to be your place of *residence*.

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

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

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

***Second opinion*** means an opportunity or requirement for a *covered person* to obtain a clinical evaluation to assess the medical necessity and appropriateness of the initial proposed health service, by a provider other than one who originally recommended or denied it.

***Self-injectable drug*** means *prescription drugs* that are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively.

***Service area*** means the geographic area in which we are authorized to sell and market our health plans, provide services as a *Health Maintenance Organization* and includes the entire state of New Mexico.

***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*** or ***specialist provider*** means a *physician* or non-physician health care professional who:

(a) focuses on a specified area of physical or *behavioral health* or specific group of patients; and
(b) Has successfully completed required training and is recognized by the state in which the health care professional practices to provide specialty care.

***Specialist physician*** means a *physician* who is not a *PCP.*

***Spouse*** means your lawful wife or husband.

***Stabilize*** means to provide physical or *behavioral health* treatment of a condition as may be necessary to ensure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a *facility* or, with respect to an *emergency* birth with no complications resulting in a continuing *emergency*, to deliver the child and the placenta.

***Subscriber*** means the primary individual who applied for this insurance *policy*.

***Substance use disorder*** means a disorder that affects a person's brain and behavior, leading to an inability to control his/her use of substances (e.g., alcohol, medications and legal or illegal drugs). Symptoms can range from moderate to severe, with addiction being the most severe form of a substance use disorder. Substance use disorder benefits are defined as benefits for items or services for substance use disorder conditions listed in ICD 10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

***Summary of Benefits and Coverage (SBC)*** means a comprehensive listing of *covered services* and applicable *cost sharing*.

***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.

***Surprise bill reimbursement rate*** means the sixtieth ($16^{th}$) percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders; provided that no *surprise bill reimbursement rate* shall be paid at less than one hundred fifty percent (150%) of the 2017 *Medicare* reimbursement rate for the applicable health care service provided.

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

***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*.

***Telehealth*** means the use by a health care professional of interactive, simultaneous audio and/or video or store-and-forward technology or any combination thereof using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

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

***Terminally ill*** means a *physician* has given a prognosis that a *member* has six months or less to live.

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

***Tobacco or nicotine use*** or ***use of tobacco or nicotine*** means *use of tobacco or nicotine* by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *policy* was completed by the *member*, including all tobacco and nicotine products, e-cigarettes or vaping devices, but excluding religious and ceremonial uses of tobacco.

***Transcranial magnetic stimulation (TMS)*** means 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.
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*** means *medically necessary* health care services provided in emergencies or after a *PCP's* normal business hours for unforeseen conditions due to *illness* or *injury* that are not life-threatening but require prompt medical attention.

***Urgent care center*** means a *facility*, not including a *hospital* emergency room or a *physician's* office, that provides treatment or services that are required:
1. To prevent serious deterioration of a *member's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

***Urgent care situation*** means a situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:
1. The life or health of the *covered person* would otherwise be jeopardized;
2. The *covered person*'s ability to regain maximum function would otherwise be jeopardized;
3. In the opinion of a *physician* with knowledge of the *covered person*'s medical condition, delay would subject the *covered person* to severe pain that cannot be adequately managed without care or treatment;
4. The medical exigencies of the case require expedited care; or
5. The *covered person*'s claim otherwise involves *urgent care*.

***Utilization review*** means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

# Dependent Member Coverage

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

1. The date you became covered under this *policy;*
2. The date of marriage to add a *spouse*;
3. The date of an eligible newborn's birth;
4. The date that an adopted child is placed with you or your *spouse* for the purposes of adoption or you or your *spouse* assumes total or partial financial support of the child;
5. The date a foster child is placed in your custody;
6. The date you are required by a court order or administrative order to provide coverage for an *eligible child*;
7. The date you are required to provide coverage for a dependent student due to *medically necessary* leave of absence.
8. The date a domestic partnership is established, pursuant to state law.

**Effective Date for Initial Dependent Members**
your *dependent members* included in the initial enrollment application for this *policy* will be covered on your *effective date*.

**Coverage for a Newborn Child**
An *eligible child* born to you or a covered family *member will* be covered from the time of birth until the 31st *day* after its birth, unless we have received notice from the entity that you have enrolled (either the Exchange or us). An *eligible child* will be covered until the 31st *day* after its birth regardless of whether notification is provided, but failure to provide such notification will prevent the child from being covered afterwards. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Summary of Benefits and Coverage (SBC)*.

*Covered services* for a newborn child include:

1. *Illness or Injury* including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care *facility* for newly born infants.
2. Newborn visits in the *hospital* by the newborn's *PCP.*
3. Circumcision for newborn males.
4. Coverage for incubator.
5. Routine *hospital* nursey charges.

Additional premium will be required to continue coverage beyond the 31st *day* after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to us by the Exchange within the 31 *days* from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 *days* after the birth of the child. If notice is not given within the 31 *days* from birth, we will charge an additional premium from the date of birth. If notice is given by the Exchange within 60 *days* of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st *day* after its birth, unless we have received notice by the Exchange of the child's birth.

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

The child will be covered for *loss* due to *illness* and *injury* including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond the 31st *day* following *placement* of the child and when we have received notification from the Exchange. 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 Exchange within 60 *days* of the birth or placement and (B) any additional premium required for the addition of the child within 90 *days* of the date of *placement.*

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

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

**Coverage for a Child Born Out of Wedlock**

We will not deny enrollment of a child if the child's parent is covered under this *policy* on the grounds that:

1. The child was born out of wedlock;
2. The child is not claimed as a dependent on the parent's federal tax return; or
3. The child does not reside with the parent or does not reside in our *service area*.

**Coverage for a Child with Coverage through Insurance of Noncustodial Parent**

When a child has coverage through an insurer of a noncustodial parent, we shall:

1. Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;
2. Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for *covered services* without the approval of the noncustodial parent; and
3. Make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the provider or the state Medicaid agency.

**Court Order to Provide Child Coverage**

When you are required by a court order or an administrative order to provide coverage for an *eligible child* we shall:

1. Permit the eligible parent to enroll, under the family coverage under this *policy*, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
2. If the eligible parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and
3. Not disenroll or eliminate coverage of the child unless we are provided satisfactory written evidence that the court or administrative order is no longer in effect.

**Adding Other Dependent Members**

If you are enrolled in an off-exchange policy and apply in writing or directly at enroll.ambetterhealth.com to add a dependent and you pay the required premiums, we will send you written confirmation of the added dependent's *effective date* of coverage and a *member* identification card for the added *dependent member*.

# Ongoing Eligibility

**For All Members**

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*;
2. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan;
3. The date we receive a request from you to terminate this *policy*, or any later date stated in your request, or if you are enrolled through the New Mexico Health Insurance Exchange (Exchange), the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *policy* or the date that we have not received timely premium payments in accordance with the terms of this *policy*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this *policy*); or
6. The date of a *member's* death.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status) or questions related to your health insurance coverage, contact the New Mexico Health Insurance Exchange at www.bewellnm.com or 1-833-862-3935. If you enrolled through Ambetter, you can contact Member Services at 1-833-945-2029 (TTY 711).

**For Dependent Members**

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

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 disability or physical disability that began before the age limit was reached; and
2. Mainly dependent on you for support.

**Open Enrollment**

There will be an open enrollment period for coverage on the Exchange. The open enrollment period begins November 1, 2022 and extends through January 15, 2023. *Qualified individuals* who enroll on or before December 15, 2022 will have an *effective date* of coverage on January 1, 2023.

**Special and Limited Enrollment**

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

1. A *qualified individual* or *dependent* experiences a loss of *minimum essential coverage,* non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care 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, placement for adoption, placement in foster care, or a child support order or other court order;
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 Exchange or b, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as maybe necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to the Exchange that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the enrollee'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 premium tax credits* or has a chance in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, or an Alaskan native 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 Exchange, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Exchange may provide;
12. A *qualified individual* newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA);
13. An enrollee loses access to their Exchange plan as a result of death;
14. An enrollee loses access to their Exchange plan as a result of divorce or legal separation;
15. Current employer plan no longer considered qualifying employer coverage;
16. An enrollee loses eligibility for Medicaid, *Medicare* or CHIP; or
17. An enrollee is a survivor of domestic violence, abuse or spousal abandonment.

The Exchange 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 premium tax credits* or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advance premium tax credits* and *cost sharing reduction* payments until the first of the next month.

For additional information, please contact the New Mexico Health Insurance Exchange at www.bewellnm.com/ or 1-833-862-3935.

**Prior Coverage**

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this *policy* and prior coverage is terminating immediately before the *effective date* of this *policy* furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this *policy* 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* services after the *effective date*, your coverage will apply for *covered services* related to the *inpatient* services after your *effective date*. Your coverage requires you to notify us within two *days* of your *effective date* or as soon as reasonably possible so we can review and *authorize medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the *allowed amount* and you may be billed for any balance of costs above the *allowed amount*.

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

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

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 ten (10) *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 *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify Bewellnm, 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. A *member* is not eligible to re-enroll once terminated, unless a *member* enrolls during an annual open enrollment period or has a special enrollment period circumstance, such as a marriage or birth in the family.

**Third Party Payment of Premiums or Cost Sharing**
We require each policyholder to pay his or her premiums and this is communicated on your monthly billing statements. Our 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 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;
5. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA)plan; or
6. 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 premium remain due. If an HRA is offered, employer payments would be acceptable and exempt from the *limitation*.

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

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

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

# Prior Authorization

Ambetter reviews services to ensure the care you receive is the best way to help improve your health condition. *Utilization review* includes:

- Pre-service or *prior authorization* review – occurs when a medical service has been pre-approved by Ambetter
- Concurrent review – occurs when a medical service is reviewed as they happen (e.g., *inpatient* stay or *hospital* admission)
- Retrospective review – occurs after a service has already been provided.

**Prior Authorization Required**

Some *covered services* require *prior authorization*. In general, *participating 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*. Please refer to Services from Non-Network/Non-Participating Providers section below.

For services or supplies that require *prior authorization*, as shown in the Services Requiring Prior Authorization provision of this *policy*, you must obtain *authorization* from us before you or your *dependent member:*

1. Receive a service or supply from a *non-participating provider;* or
2. Receive a service or supply from a *participating provider* to which you or your *dependent member* were referred to by a *non-participating provider.*

*Prior authorization* must be obtained for services or supplies after you or a *dependent member* are admitted into a *network facility* by a *non-participating provider* once emergency room transfer or *urgent care* stabilization has occurred.

*Prior authorization* requests must be received by phone/e-fax/provider portal as follows:

1. At least 7 *days* prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice facility*.
2. At least 7 *days* prior to the initial evaluation for organ transplant services.
3. At least 7 *days* prior to receiving clinical trial services.
4. Within 24 hours of an admission for an *inpatient* admission, including for *mental health disorder* or *substance use disorder* treatment.
5. At least 7 *days* prior to the start of *home health care*.

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 urgent concurrent reviews within 24 hours (one calendar *day*) of receipt of the request.
2. For urgent *pre-service* reviews, within 24 hours (one calendar *day*) from date of receipt of request.
3. For non-urgent *pre-service* reviews within seven calendar *days*, of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar *days* of receipt of the request.

**How to Obtain Prior Authorization**

To obtain *prior authorization* or to confirm that a *participating provider* has obtained *prior authorization*, contact us by telephone at the telephone number listed on your *member* 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 may result in denial of payment.

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

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

**Services from Non-Network/Non-Participating Providers**
Except for *emergency* medical services, we do not normally cover services received from *non-participating providers*. If a situation arises where a *covered service* cannot be obtained from a *participating provider* located within a reasonable distance, we may provide *prior authorization* for you to obtain services from a *non-participating provider* at no greater cost to you than if you went to a *participating provider*. If *covered service*s are not available from a *participating provider,* you or your *PCP* must request *prior authorization* from us before you may receive services from a *non-participating provider*.

**Services Requiring Prior Authorization**
1. Adult accidental dental
2. Bariatric *surgery inpatient*
3. Bone anchored hearing aids
4. Cardiac *rehabilitation*
5. Cochlear implants
6. Corrective footwear orthotics shoes inserts
7. *Inpatient* services maternity care
8. Diabetic footwear
9. Diabetic footwear orthotics
10. *Durable medical equipment*
11. Hearing aid supplies batteries
12. *Home health care*
13. Imaging
14. Infertility diagnostic testing
15. Inherited metabolic disorder
16. *Inpatient facility* admission
17. *Inpatient* mental health
18. *Inpatient rehabilitation*
19. *Inpatient substance use disorders*
20. Mastectomy bra
21. Neurodevelopmental therapy
22. Neurological *rehabilitation*
23. Outpatient *rehabilitation*
24. Outpatient mental health and *substance use disorders* (excludes office visits)
25. Outpatient *surgery* doctor
26. Outpatient *surgery facility*
27. Private duty nursing
28. *Respite care*
29. Rx preferred drug (may require *prior authorization*)
30. Rx specialty drug (may require *prior authorization*)
31. Rx specialty mail drug (may require *prior authorization*)
32. *Specialist* visit
33. Skilled nursing *facility*
34. Sleep study
35. TMJ treatment
36. Transplant
37. Wigs

# Cost Sharing Features

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

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 *policy* 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 *policy* and in your *Summary of Benefits and Coverage (SBC)*.

**Deductible**
The *deductible amount* means the amount of *covered services* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amoun*t does not include any *copayment amount* or *coinsurance amount*. Not all *covered services* are subject to the *deductible amount*. See your *Summary of Benefits and Coverage (SBC)* for more details.

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

**Coinsurance Percentage**
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) 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 *maximum out-of-pocket amount* has been met, additional *covered service expenses* will be provided at 100 percent.

**Maximum Out-of-Pocket**
You must pay any required *copayment amounts* or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Summary of Benefits and Coverage*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent 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 *member*s' *eligible expenses*.

*Cost sharing* incurred for *emergency services* and *authorized* non-emergency care from a *non-participating provider*, will be applied towards your *maximum out-of-pocket amount*. Additionally, *cost sharing* incurred for unanticipated non-network services covered under this *policy* and provided by a *non-participating provider* at a *network facility*

will be applied towards your *maximum out-of-pocket amount*, unless you gave informed consent before receiving the services.

The amount provided or payable will be subject to:
1. Any specific benefit limits stated in the *policy*; and
2. A determination of *eligible expenses*.
3. Any reduction for expenses incurred at a *non-participating provider*. Please refer to the information on the *Summary of Benefits and Coverage*.

The applicable *deductible amount(s), coinsurance amount,* and *copayment amounts* are shown on the *Summary of Benefit and Coverage (SBC)*.

**Non-Participating Liability and Balance Billing**
If you receive services from a *non-participating provider*, you may have to pay more for services you receive. *Non-participating providers* may be permitted to bill you for the difference between what we agreed to pay and the full amount charged for a service. This is known as *balance billing*. This amount is likely more than *participating* costs for the same service and might not count toward your annual *maximum out-of-pocket amount* limit.

When receiving care at a participating *facility*, it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *participating providers*. We encourage you to inquire about the providers who will be treating you before you begin your treatment, so that you can understand their *network* participation status with us.

As a *member*, *non-participating providers* should not bill you for *covered services* for any amount greater than your applicable participating *cost sharing* responsibilities when:
1. You receive a covered *emergency service* or air *ambulance service* from a *non-participating provider*. This includes services you may get after you are in stable condition, unless the *non-participating provider* obtains your written consent.
2. You receive non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as, diagnostic services (including radiology and laboratory services)) from a *non-participating provider* at a *network hospital* or *network* ambulatory surgical *facility*.
3. You receive other non-emergency services from a *non-participating provider* at a *network hospital* or *network* ambulatory surgical *facility*, unless the *non-participating provider* obtains your written consent.

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# Access to Care

**Primary Care Practitioner (PCP)**
In order to obtain benefits, you must designate a *network PCP* for each *member.* If you do not select a *network PCP* for each *member*, one will be assigned. You may select any *network PCP* who is accepting new patients from any of the following provider types:

- Family practitioners
- General practitioners
- Internal medicine
- Nurse practitioners*
- Physician assistants
- Obstetricians/gynecologists
- Pediatricians (for children)
- Doctors of oriental medicine
- Chiropractic *physician*s
- Certified nurse midwives

*If you choose a nurse practitioner as your PCP, your benefit coverage and *copayment amounts* are the same as they would be services from other *network providers*. See your *Summary of Benefits and Coverage* for more information.

Any female *member* age 13 or older may designate an OB/GYN as a *network PCP*. You may obtain a list of *network PCPs* at our website at Ambetter.WesternSkyCommunityCare.com/findadoc or by contacting Member Services.

You should get to know your PCP and establish a health relationship with them. Your PCP will:

- Provide *preventive care* and screenings
- Conduct regular physical examinations as needed
- Conduct regular immunizations as needed
- Deliver timely service
- Work with other doctors when you receive care somewhere else
- Coordinate specialty care with *network specialist physicians*
- Provide any ongoing care you need
- Update your *medical record*, which includes keeping track of all the care that you get from all of your *providers*
- Treat all patients the same way with dignity and respect
- Make sure you can contact him/her or another provider at all times
- Discuss what advance directive are and file directives appropriately in your *medical record*.

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

**Changing Your Primary Care Practitioner (PCP)**
You may change your *network PCP* 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 PCP* of record will be effective no later than 30 *days* from the date we receive your request.

**Contacting Your Primary Care Practitioner (PCP)**
To make an appointment with your PCP, call his/her office during business hours and set up a date and time. If you need help, call Member Services at 1-833-945-2029 and we will help you make the appointment.

If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and a photo identification.

Should you need care outside of your PCP's office hours, you should call your PCP's office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your PCP during normal office hours, call our 24/7 nurse advice line at 1-833-945-2029 (TTY 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

**Referral Required for Maximum Benefits**
You do not need a referral from your *network PCP* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians,* you may be required to obtain a referral from your *network PCP* for benefits to be payable under your *policy* or benefits payable under this *policy* may be reduced. Please refer to your *Summary of Benefits and Coverage (SBC)*.

**Referral to a Specialty Care Provider**
Your *PCP* will provide a referral to a *specialty care* provider when additional specialized care is needed. We will not limit any *PCP* from referring to practitioners not in *network* when treatment is *medically necessary*, and no *network provider* is available to provide the care needed. This *policy* includes referrals to other parts of the state or country as needed. The *PCP* will work with us on identifying referral *provider*s. We are responsible for providing all *members* written notice of any services that will not be covered by the health plan benefits when referred to a non-network *provider*. You as a *member* would not be responsible for paying for services not *covered* due to any referrals to a non-network practitioner with us unless you received an official letter from us alerting you that we will not be responsible for future payments to the non-network practitioner.

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

**Non-Emergency Services**
If you are traveling outside of the New Mexico *service area* you may be able to access *providers* that contract with us in another state. You can locate Ambetter *providers* outside of New Mexico by searching the relevant state in our Provider Directory at Ambetter.westernskycommunitycare.com/findadoc. Not all states have *providers* that contract with us. If you receive non-emergency *covered services* from an Ambetter *provider* outside of the *service area*, *prior authorization* may be required. Contact Member Services at the phone number on your identification card for further information.

Except for *emergency* health services or services for *dependent members* residing outside the *service area*, if a *member* wishes to receive benefits for *covered services* from a *provider* who is outside the *service area*, the *member* must ensure that the out-of-area non-contracted *provider* requests *prior authorization* for the services or supplies. We will apply our Medical Coverage Policies when evaluating the *medical necessity* for the services provided by the out-of-area *provider*, which includes considering the absence of or the exhaustion of all *network* resources. Failure to request *prior authorization* for non-contracted *providers* will result in denial of coverage. *Prior authorization* does not guarantee payment or assure coverage; all claims for benefits delivered by an out-of-area *provider* are subject to all other terms, conditions, exclusions and limitations of coverage.

If you are temporarily out of the *service area* and have a medical or *behavioral health emergency*, call 911 or go to the nearest emergency room. Be sure to call us and report your *emergency* within one business *day* or as soon as reasonably possible. You do not need *prior authorization* for *emergency* care services.

**Emergency Services Outside of Service Area**
We cover *emergency care* services when you are outside of our *service area*. If you are temporarily out of the *service area* and have a medical or *behavioral health* emergency, call 911 or go to the nearest emergency room. Be sure to call us and report your *emergency* within one business *day* or as soon as reasonably possible. You do not need prior approval for *emergency care* services.

**Continuity of Care**
Under the No Surprises Act, if a *member* is receiving a *covered service* with respect to an *network provider* or *facility* and (1) the contractual relationship with the provider or *facility* is terminated, such that the provider or *facility* is no longer in the *network*; or (2) benefits are terminated because of a change in the terms of the participation of the provider or *facility*, as it pertains to the benefit the *member* is receiving, then we will: (1) notify each enrollee who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider or *facility*; (2) provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and (3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a continuing care patient during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-*day* period beginning on such date; or the (ii) date on which such individual is no longer a continuing care patient with respect to their provider or *facility*.

If a *member* has entered the third trimester of pregnancy at the time of the *provider's* termination, the transitional period will include post-partum care directly related to the delivery.

If a newly enrolled *member's* health care *provider* is not a *participating provider*, the *member* may continue an ongoing course of treatment with their current health care *provider* for a transitional period of time of at least 30-*days* and as authorized.

**Hospital Based Providers**
When receiving care at a participating *hospital* it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists and intensivists) may not be under contract with us as *participating providers*. If appropriate notice is provided to and acknowledged by you before rendering services, you may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by us – this is known as "*balance billing*". We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with us. Any amount you are obligated to pay to the *non-participating provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

You may not be balanced billed for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology and neonatology, as well as, diagnostic services (including radiology and laboratory services)) received from a *non-participating provider* at a participating *hospital* or participating ambulatory *facility*.

**New Technology**
Health technology is always changing. If we think a new medical advancement can benefit our *members*, we evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our *members*. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we

should change any of our benefits to include the new technology.

If the CPC does not review a request for coverage of new technology, our Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request a future meeting.

# Major Medical Expense Benefits

Ambetter from Western Sky Community Care coverage for health care services for a *member* or covered dependents. Some services require *prior authorization*. *Deductibles*, *copayment amounts* and *coinsurance amounts* must be paid to your *participating provider* at the time you receive services. All *covered services* are subject to conditions, exclusions, *limitations*, terms and provision of this *policy*. *Covered services* must be *medically necessary* and not *experimental or investigational*.

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 disorder* and *substance use disorder* services, including *behavioral health* treatment, *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this *policy* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum.

**Benefit Limitation**
*Limitations* may also apply to some *covered services* that fall under more than one *covered service* category. Please review all limits carefully. Ambetter from Western Sky Community Care will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

## Acquired Brain Injury Services

Benefits for *eligible expenses* incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition. Cognitive *rehabilitation therapy*, cognitive communication therapy, neurocognitive therapy and *rehabilitation*; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation required for and related to treatment of an *acquired brain injury*, post-acute transition services and community reintegration services, including outpatient day treatment services or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an *acquired brain injury*.

Treatment for an *acquired brain injury* may be provided at a *hospital*, an acute or post-acute *rehabilitation hospital*, an assisted living *facility* or any other *facility* at which appropriate services or therapies may be provided. Services means the work of testing, treatment and providing therapies to an individual with an *acquired brain injury*. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

To ensure that appropriate post-acute care treatment is provided, this *policy* includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an *acquired brain injury*;
2. Has been unresponsive to treatment; and
3. Is medically stable; and
4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered with the expectation that the provision of these services and support, the person can return to a community-based setting rather than reside in a *facility* setting.

## Ambulance Service Benefits

*Prior authorization* is not required for *emergency* ambulance transportation. **Note:** Non-emergency ambulance transportation requires *prior authorization*.

*Covered services* will include *ambulance services* for ground and water transportation, transportation from home, scene of accident or medical *emergency*:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
2. Transportation, including air transport, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest tertiary care *facility*.
3. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by us.

**Note:** Unless otherwise required by Federal or New Mexico law, if you receive services from non-network ambulance providers, you may be responsible for costs above the *allowed amount*.

*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. *Ambulance services* provided for a *member's* comfort or convenience.
3. Non-emergency transportation excluding ambulances (for example, transport-van, taxi).

## Air Ambulance Service Benefits

*Covered services* will include *ambulance services* for transportation by fixed wing and rotary wing air ambulance from home, scene of accident or medical emergency:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
2. Transportation, including air transport, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest tertiary care *facility*.
3. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by us.

*Prior authorization* is not required for *emergency* air ambulance transportation. **Note:** You should not be *balance billed* for services from a non-network air ambulance provider, beyond your *cost share*, for air *ambulance services*.

Benefits for air *ambulance services* are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

*Exclusions*:
No benefits will be paid for:

1. Expenses incurred for air *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance.
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.

4. Air *ambulance services* provided for a *member's* comfort or convenience.

## Autism Spectrum Disorder Benefits

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

*Covered services* for *autism spectrum disorder* are not subject to annual or lifetime limits. These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the same *day* by different *providers*, a separate *copayment amount* and/or *coinsurance amount* will apply to each provider.

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

- evaluation and assessment services;
- *applied behavior analysis* therapy;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy;
- psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

## Bariatric Surgery

Surgical treatment of morbid obesity (bariatric *surgery*) is *covered* only if it is *medically necessary*. Bariatric *surgery* is covered for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and if a *member* meets these criteria and all other requirements of this plan.

## Weight Loss Programs

*Covered services* include dietary evaluations and counseling for the medical management of morbid obesity and obesity. Coverage also includes *prescription drugs* that are *medically necessary* for the treatment of obesity and morbid obesity. See also benefits described under the Bariatric Surgery provision (above). The following are not covered: Treatments and medications for the purpose of weight reduction or control, except for *medically necessary* treatment of morbid obesity and obesity. Exercise equipment, personal trainers, club memberships and weight reduction programs.

## Contraceptive Coverage

You are entitled to receive certain covered contraception services and supplies without cost sharing and without *prior authorization* from us. This means that you do not have to make a *copayment amount, coinsurance amount*, satisfy a *deductible amount* or pay out-of-pocket for any part of contraception benefits listed under this provision if you receive them from a *participating provider*.

You may be required to pay a *deductible amount, copayment amount* and/or *coinsurance amount*, if you receive a contraception service or supply from a *non-participating provider* if the same service or supply is available from a *participating provider*. You may also owe *cost sharing* if you receive a brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

<u>Covered Contraceptive Methods</u>

Your plan covers these contraceptive methods:

- Sterilization *surgery* for women
- Sterilization *surgery* for men

- Intrauterine device (IUD) copper
- Intrauterine device (IUD) with progestin
- Implantable rod
- Shot/Injection
- Oral contraceptives (the "pill") (combined "pill")
- Oral contraceptives (extended/continuous use)
- Oral Contraceptives (mini "pill" – progestin only)
- Patch
- Vaginal contraceptive ring
- Diaphragm with spermicide
- Sponge with spermicide
- Cervical cap with spermicide
- Male condom
- Female condom
- Spermicide
- Emergency contraceptive – "Plan B"
- Emergency contraceptive – "Ella"

Long-Acting Reversible Contraceptives
The long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) are covered without *cost sharing* by your plan are listed here: Contraceptive Coverage Summary. Coverage with no *cost sharing* also applies to intrauterine device (IUD) insertion and removal, including surgical removal, and to any related medical examination when services are obtained from a *participating provider*. Coverage of LARCs with no *cost sharing* also includes (pre-discharge) postpartum clinical services.

Oral Contraceptives
The oral contraceptives covered by your plan are listed here: Contraceptive Coverage Summary.

Six Month Dispensing
You are entitled to receive a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. To receive this benefit, your *provider* must specifically prescribe the six-month supply. If you need to change your contraceptive method before the six-month supply runs out, you may do so without *cost sharing*. You will not owe *cost sharing* for any related contraceptive counseling or side-effects management.

Brand Name Drugs or Devices
Your plan may exclude or apply *cost sharing* to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Please see the table of contraceptive categories above. Ask your *provider* about a possible equivalent.

If your provider determines that a brand-name contraceptive is medically necessary, your provider may ask us to cover that contraceptive without cost-sharing. If we deny the request, you or your provider can submit a grievance to contest that denial.

Vasectomies and Male Condoms
This plan covers vasectomies and male condoms. No prescription or *cost sharing* is required for coverage of male condoms. Please see the provision below on Coverage for Contraception Where a Prescription Is Not Required for instructions on reimbursement for condoms.

Sexually Transmitted Infections
Your plan covers and no *cost sharing* applies to, contraception methods that are prescribed for the prevention of sexually transmitted infections.

Coverage for Contraception Where a Prescription Is Not Required
Your plan covers contraception with no *cost sharing* even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a prescription when obtained through a *network* pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within 90 days of the date of purchase of the contraceptive method,
- Provide the receipt with the reimbursement form available at Contraceptive Reimbursement Form, to the following:

Mail: Ambetter from Western Sky Community Care
Claims Department-Member Reimbursement
PO Box 5010
Farmington, MO 63640-5010
Fax: 1-833-395-5940
Email: WSCC.pharmacy@westernskycommunitycare.com

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within 30 days of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within 45 days. Failure to submit a complete request may lead to delays in reimbursement.

Availability of Out-of-Network Coverage
Under your plan, use of a *non-participating provider* to prescribe or dispense contraceptive coverage is not a *covered service*.

## Coronavirus; COVID-19 Public Health Emergency
Coverage includes testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency when declared by the state of New Mexico or federal government.

There are no *member cost sharing* requirements for testing, vaccination(s) and/or delivery of health care services that are related to COVID-19.

## Diabetic Care
Benefits are available for *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes. *Covered services* include, but are not limited to, diabetes education when received from a *medical practitioner*/provider who is approved to provide diabetes education; examinations including podiatric examinations; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing and self-management equipment. *Covered services* include diabetes supplies such as:

- blood glucose monitors, including those for the legally blind;
- test strips for blood glucose monitors;
- visual reading urine and ketone strips;
- lancets and lancet devices;
- insulin;
- injection aids, including those adaptable to meet the needs of the legally blind;
- syringes;
- prescriptive oral agents for controlling blood sugar levels'

- *medically necessary* podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and
- glucagon emergency kits.

Insulin: The total amount you will be required to pay for a covered insulin medication will not exceed $25 per 30-*day* supply. If your *cost share* per 30-*day* supply of insulin medications is less than $25, you will be responsible for the lower amount. Please refer to our formulary for tier placement of insulin medications and your *Summary of Benefits and Coverage (SBC)* for your *cost share* responsibility for the associated drug tier.

The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federal mandated limits.

## Dialysis Services

*Medically necessary* acute and chronic dialysis services are *covered services* 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 a *network* dialysis *facility* or peritoneal dialysis in your home from a *participating provider* when you qualify for home dialysis.

*Covered services* include:

- Services provided in an outpatient dialysis *facility* or when services are provided in the home;
- Processing and administration of blood or blood components;
- Dialysis services provided in a *hospital*;
- Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

## Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics

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 *allowed amount* for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum *allowed amount* for the standard item which is a *covered service* is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment, and replacement of purchased equipment, supplies, or appliances as set forth below may be covered, as *approved* by us. The repair, adjustment, or replacement of the purchased equipment, supply, or appliance is covered if:

- The equipment, supply, or appliance is a *covered service*;
- The continued use of the item is *medically necessary*; and
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

equipment *specialist* or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:
- Repair and replacement due to misuse, malicious breakage, or gross neglect.
- Replacement of lost or stolen items.

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

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

*Covered services* and supplies may include, but are not limited to:
1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. Augmentive communication devices are covered when we *approve* based on the *member's* condition.

*Exclusions*:
Non-covered items may include, but are not limited to:
1. Air conditioners.
2. Ice bags/cold pack 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.
8. Vehicle installations or modifications which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

See your *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.

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

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

1. Allergy serum extracts.
2. Chem strips, Glucometer, Lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies, except charges such as those made by a pharmacy for purposes of a fitting, are not *covered services*.
6. Disposable medical supplies – disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to, bandages and wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes and applicators. The supplies are subject to the *member's* medical *deductible amount*, *copayment amount* and/or *coinsurance amount.*

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

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

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

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

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

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

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

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

specified under the Medical and surgical supplies provision).
4. Garter belts or similar devices.

Prosthetics

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

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

Benefits for prosthetics and other *medically necessary* health care services related to gender affirming care and the treatment for gender dysphoria will be covered.

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

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

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

*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.
   Wigs (except as described above following cancer treatment).

## Family, Infant and Toddler (FIT) Program

We provide coverage to *dependent* children, from birth through three years of age, who qualify for services through the Family, Infant, and Toddler (FIT) Program. The FIT Program is administered by the New Mexico Department of Health. The program provides intervention services for children who have or are at risk for early developmental delays and/or disabilities. We cover *medically necessary* early intervention services provided as part of an individualized family plan to *dependent* children who are enrolled in the FIT Program with the New Mexico State Department of Health. They must receive such services from designated and approved FIT Program *providers*. Coverage and services are provided as defined in the requirements for the FIT Program Early Intervention Services under New Mexico law.

The maximum benefit is $3,500 per dependent and enrolled child during each *calendar year*. Outpatient Office Visit *cost sharing* will apply. No payments under this section are applied to any maximums or annual limits under this *policy*.

## Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

*Covered services* include outpatient *facility* fees and services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following *limitations*:

1. *Covered services* 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 be determined *medically necessary*.
3. *Covered services* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the United States Food and Drug Administration.
4. *Covered services* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient rehabilitative physical therapy, occupational therapy, and speech therapy.

*Custodial care* services are not covered under this *policy*. See your *Summary of Benefits and Coverage (SBC)* to determine applicable *member cost sharing*.

Care ceases to be *medically necessary rehabilitation* for any of the following:

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

## Home Health Care Service Expense Benefits

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

1. *Home health aide services*, only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Services of a private duty registered nurse or licensed practical nurse rendered on an outpatient basis. Please refer to your *Summary of Benefits and Coverage (SBC)* for any limits associated with this benefit.

3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.* Please refer to your *Summary of Benefits and Coverage (SBC)* for any limits associated with this benefit.
4. Intravenous (I.V.) medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*, drugs and medicines, and laboratory services, to the extent they would have been covered if provided to the *member* on an impatient basis.
7. Rental of *medically necessary durable medical equipment* at the discretion of the plan. 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.

Intravenous (I.V.) medication and pain medication are *covered services* to the extent they would have been *covered service*s during an *inpatient hospital* stay. At our option, we may *authorize* the purchase of the equipment from a *participating provider* 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 *respite care, custodial care,* or educational care under the Home Health Care Service Expense Benefit.

## Hospice Care Service Expense Benefits

*Hospice care* may be provided in the home or at a hospice *facility* where medical, social, and psychological services are given to help treat patients with a *terminal illness*. Hospice services include routine home care, continuous home care, *inpatient* hospice, and *inpatient* respite. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member*. Respite days that are applied toward the *deductible* are considered *covered services* and shall apply against any maximum benefit limit for these services. See the *Summary of Benefits and Coverage* for benefit levels or additional limits.

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

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

## Hospital Benefits

*Covered services* 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. A private *hospital* room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, treatment, or recovery room.
5. Outpatient use of an operating, treatment, or recovery room for *surgery.*
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
7. *Emergency* treatment of an *illness* or *injury*, even if confinement is not required. See your *Summary of Benefits and Coverage (SBC)* for *limitations*.

## Emergency Room Services

In an emergency situation (anything that could endanger your life (or your unborn child's life)), you should call 911 or head straight to the nearest emergency room. We cover emergency medical and *behavioral health* services both in and out of our *service area*. We cover these services 24 hours a *day*, 7 *days* a week.

## Long Term Acute Care (LTACH)

Long-term acute care *hospitals* (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods when *medically necessary* and approved by us.

Common conditions/services that may be considered *medically necessary* for LTACH level of care includes, but are not limited to:

- Complex wound care:
  - Daily *physician* monitoring of wound
  - Wound requiring frequent complicated dressing changes and possible repeated debridement of necrotic tissue
  - Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
  - Lower extremity wound with severe ischemia
  - Skin flaps and grafts requiring frequent monitoring
- Infectious disease:
  - Parenteral anti-infective agent(s) with adjustments in dose
  - Intensive sepsis management
  - Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
- Medical complexity:
  - Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
  - Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
- Rehabilitation:
  - Care needs cannot be met in a *rehabilitation* or skilled nursing *facility*
  - Patient has a comorbidity requiring acute care
  - Patient is able to participate in a goal-oriented *rehabilitation* plan of care
  - Common conditions include CNS conditions with functional *limitations*, debilitation,
  - amputation, cardiac disease, orthopedic *surgery*

- Mechanical ventilator support:
    - Failed weaning attempts at an acute care facility
    - Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/day
    - Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
    - Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
    - Patient is hemodynamically stable and not dependent on vasopressors
    - Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
    - Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders

Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

## Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed *physician* or received in a *hospital* or other public or private *facility* authorized to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

## Medical Expense Benefits

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

1. Made by a *physician* or *specialist* for professional services, including *surgery*.
2. For the professional services of a *medical practitioner*.
3. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
4. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included) which includes but are not limited to:
    a. Sleep disorder studies in home or *facility* (**Note:** *Prior authorization* is required for sleep studies only when provided in a *facility*);
    b. Bone density studies;
    c. Clinical laboratory tests;
    d. Gastrointestinal lab procedures;
    e. Pulmonary function tests.
5. For chemotherapy and radiation therapy or treatment.
6. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
7. For the cost and administration of an anesthetic.
8. For oxygen and its administration.
9. For *medically necessary chiropractic care* and acupuncture treatment on an outpatient basis only. Benefits for *chiropractic care* and acupuncture treatment are limited to 20 visits each per calendar year. *Covered services* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *cost sharing* provisions.
10. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation, reversal of vasectomy, reversal of tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
11. *Medically necessary services* made by a provider who renders services in a *network urgent care center*, including *facility* costs and supplies.
12. Radiology services, including X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CAT scan), Positron Emission Tomography (PET scan), and ultrasound imaging.
13. Allergy services including testing and sera.

14. Allergy serum extracts.
15. For *medically necessary* genetic blood tests.
16. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
17. For *medically necessary* biofeedback services.
18. For *medically necessary* allergy treatment.
19. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
20. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
21. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and *surgery* in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.
22. *Telehealth* services provided by Ambetter Telehealth vendors are subject to $0 *copayment amount*. *Telehealth* services not provided by Ambetter Telehealth vendors would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in-person.
23. For pulse oximetry screening on a newborn.
24. Well child care examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Refer to **Preventive Services** provision for a list of well child/well baby services.
25. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
26. For the cost and administration of an anesthetic.
27. 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 *health care professional* has issued a written order stating that the enteral formula or food product is *medically necessary*. 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.
28. 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.
29. For respiratory and pulmonary therapy.
30. For *medically necessary* diagnostic and laboratory tests.
31. 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 health care professional has issued a written order stating that the enteral formula or food product is *medically necessary*. 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.
32. Testing of pregnant women and other *members* for lead poisoning.

*Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.

## Surgical Expense Benefits

Surgical *covered services* but not limited to charges:

1. For *surgery* in a *physician's* office, *inpatient facility*, or at an *outpatient surgical facility,* including services and supplies.
2. Made by an assistant surgeon.
3. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
4. For *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who is a *dependent member* covered under this

*policy*.

5. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. Benefits for *reconstructive surgery* will also include *medically necessary* health care services related to gender affirming care and the treatment for gender dysphoria. *Inpatient* stays will be no less than 48 hours for a mastectomy and no less than 24 hours for lymph node dissection unless ordered by a *physician*.
6. Bariatric *surgery* for *members* with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at risk for increased morbidity due to specific obesity related comorbid medical conditions.
7. For dental treatment in a *hospital* or *ambulatory surgical center*. Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or *surgery*, subject to *prior authorization* by us.
    a. A *member* under age eight (8) whose treating health care professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
    b. A *member* who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any dental treatment or *surgery* if not rendered in a *hospital* or *ambulatory surgical center*.
8. For accidental dental service expenses when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in:
    a. Damage to his or her sound natural teeth; and
    b. Expenses are incurred within six (6) months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six (6) months of the accident. *Injury* to the sound natural teeth will not include any *injury* as a result of chewing.
9. 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.
10. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
11. Cochlear implants and bone anchored hearing aids.
12. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.
13. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
    b. A prostate examination and laboratory tests for cancer for any non-symptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
    c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines.
14. 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 jawbone and is *medically necessary* to attain functional capacity of the affected part.
c. Oral/surgical correction of accidental *injuries*.
d. Treatment for temporomandibular joint (TMJ) disorder, including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
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.

*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.

*Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.

## Mental Health and Substance Use Disorder Benefits

If you need *mental health disorder* or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network behavioral health providers* at our website at Ambetter.WesternSkyCommunityCare.com/findadoc or by calling Member Services at 1-833-945-2029 (TTY 711).

*Covered services* for *mental health disorders* and *substance use disorders* are included on a non-discriminatory basis for all *members* for the diagnosis and *medically necessary* treatment of mental, emotional, or *substance use disorders* as defined in this *policy*.

When making coverage determinations, our *behavioral health* and *substance use disorder* Utilization Management staff 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 disorder* staff utilizes InterQual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* 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 disorder* and/or *substance use disorder* services are as follows:

***Inpatient***

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

**Outpatient**

1. Individual and group therapy for *mental health disorders* and *substance use disorders*;
2. Medication management services;
3. Outpatient detoxification programs;
4. Psychological and Neuropsychological testing and assessment;
5. *Applied behavior analysis* treatment for *autism spectrum disorders*;
6. *Telehealth*;
7. Partial Hospitalization Program (PHP);

8. Intensive Outpatient Program (IOP);
9. Mental health day treatment;
10. Electroconvulsive Therapy (ECT);
11. *Transcranial Magnetic Stimulation (TMS)*;
12. Evaluation and assessment for *mental health disorder* and *substance use disorder*;
13. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*; and
14. Assertive Community Treatment (ACT)

Expenses for these services are covered, if *medically necessary* and may be subject to *prior authorization*. Please see the *Summary of Benefits and Coverage (SBC)* for more information regarding services that require *prior authorization* and specific benefit limits, if any.

In addition, Integrated Care Management is available for all of your health care needs, including *behavioral health* and *substance use disorders*. Please call 1-833-945-2029 (TTY 711) to be referred to a care manager for an assessment.

**Note:** In accordance with Senate Bill 317: Applying Cost Sharing Waivers to Behavioral Health Services (applicable January 1, 2022, through December 31, 2026), *cost sharing* does not apply - deductibles, *copayment amounts* or *coinsurance amounts* - for covered *behavioral health* services (*outpatient services*, *inpatient* services and *prescription drugs*).

## Other Dental Services

Anesthesia and *hospital* charges for dental care are covered for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient *ambulatory surgical center*. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Coverage is also provided for:

1. *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 jawbone and is *medically necessary* to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental *injuries*.
    d. Treatment for Temporomandibular Joint (TMJ) disorder, including removable appliances for TMJ repositioning and related *surgery*, medical care and diagnostic services.
    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* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a *network hospital*, surgical center or office, provided to the following *members*:
    a. A *member* under the age of 19;
    b. A person who is severely disabled; or
    c. A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

3. Dental service expenses when a *member* suffers an *injury*, that results in:
    a. Damage to his or her natural teeth;
    b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

*Surgery*, excluding tooth extraction, to treat craniomandibular disorders or malocclusions.

## Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *covered person*. Coverage is limited to diabetes care only.
3. For four mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
6. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.
7. For the cost of one hearing aid per ear every three years as prescription changes. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a *physician*.

## Pediatric Routine Vision Benefits

Coverage for vision services is provided for children under the age of 19, through the end of the plan year in which they turn 19 years of age.

1. Routine ophthalmological examination
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Standard 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 evaluation/aids.

Please refer to your *Summary of Benefits and Coverage (SBC)* 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.WesternSkyCommunityCare.com or call Member Services.

Services not covered:

1. Deluxe frame/frame upgrade;
2. Visual therapy (see medical coverage);
3. Two pair of glasses as a substitute for bifocals; and
4. LASIK *surgery*

## Medical Vision Services

*Covered services* include:

- Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
- Vision screenings to determine the presence of refractive error.
- *Members* who have been diagnosed with diabetes may self-refer once each year to an eye care *specialist physician* within their *network* for the purpose of receiving an eye examination for the detection of eye disease. Continued or follow-up care from the eye care *specialist physician* may require a referral through your *participating provider*.

Vision services under the medical portion of your *policy* do not include:

- Referrals to a *specialist physician* for evaluation and diagnosis of refractive error, including presbyopia, for *members* over the age of 19 years.
- Eye examinations required by an employer or as a condition of employment.
- Radial keratotomy, LASIK and other refractive eye *surgery*.
- Services or materials provided as a result of any workers' compensation law or required by any governmental agency.
- Orthoptics, vision training or subnormal vision aids.

## Prescription Drug Expense Benefits

We work with *providers* and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases. We will accept uniform *prior authorization* forms for *prescription drugs* as sufficient to request *prior authorization* for *prescription drug* benefits. If we fail to use or accept the uniform prior authorization form or respond within three business *days,* the *prior authorization* request will be deemed granted.

*Covered services* in this benefit provision are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. Prescribed oral anticancer medication.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

Such *covered services* shall include those for prescribed, orally administered anticancer medications. The *covered services* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *policy*.

**Formulary or Prescription Drug List**
The formulary or *prescription drug* list is a guide to available generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and covered through your *prescription drug* benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost-effective treatment options, if a generic medication on the formulary is not suitable for your condition.

**Note:** Not all dosage forms or strengths of a drug may be covered. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specified drug. Drugs listed on the formulary are selected by us based upon the recommendations of a Pharmacy and Therapeutics committee, which is made up of currently practicing *physicians* and pharmacists from across the country, some of whom are employed by or affiliated with us. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the formulary. Entire drug classes are also regularly reviewed. Some of the factors committee *members* evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List. Positive changes (e.g., adding drugs to the formulary, drugs moving to a lower payment tier) can occur quarterly after review by the committee. Changes to the formulary that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or *prior authorization*) occur only annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the formulary may occur more frequently.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or *Prescription Drug* List or for more information about our pharmacy program, visit Ambetter.WesternSkyCommunityCare.com (under "For Member", "Drug Coverage") or call Member Services at 1-833-945-2029 (TTY 711).

**Over-the-Counter (OTC) Prescriptions**
We cover a variety of over-the-counter (OTC) medications when ordered by a *physician.* You can find a list of covered over-the-counter medications in our formulary – they will be marked as "OTC". Your *prescription order* must meet all legal requirements.

**Self-Injectable Drugs**
*Self-injectable drugs* are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively. *Self-injectable drugs* are covered under the *prescription drug* benefits; *prescription drug cost share* applies.

**How to Fill a Prescription**
*Prescription orders* can be filled at a *network* retail pharmacy or through our mail order pharmacy.

If you decide to have your *prescription order* filled at a *network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at Ambetter.WesternSkyCommunityCare.com/findadoc on our website. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your *member* identification card.

We also offer a three-month (90-*day*) supply of maintenance medications by mail or from *network* retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on Ambetter.WesternSkyCommunityCare.com. You can also request to have a copy mailed directly to you.

**Mail Order Pharmacy**
If you have more than one prescription you take regularly, you may select to enroll in our mail order delivery program. Your prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment amount/coinsurance amount*. To enroll for mail order delivery or for any additional questions, call our mail order pharmacy at 1-888-624-1139. Alternatively, you can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on our Ambetter website. Once on our website, click on the section, "For Member," "Drug Resources." The enrollment form will be located under "Forms."

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

**Extended Days' Supply**
Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills of select maintenance medications are available at *network* pharmacies.

**Medication Balance-On-Hand**
Medication refills are prohibited until your cumulative balance-on-hand is equal to or fewer than 15 *days*' supply of medication. This provision operates in addition to any applicable medication quantity limit or refill guidelines.

**Topical Ophthalmic Products**
A *member* can receive early refills of topical ophthalmic products in the following manner:
1. After 21 *days* or more but before 30 *days* after receiving any 30-*day* supply of the product;
2. After 42 *days* or more but before 60 *days* after receiving any 60-*day* supply of the product; or
3. After 63 *days* or more but before 90 *days* after receiving any 90-*day* supply of the product.

**Medication Synchronization**
In accordance with state regulations, upon request, a *member* taking two or more chronic *prescription drugs* may ask a *network* pharmacy to synchronize refill dates so that *drugs* refilled at the same frequency may be refilled concurrently. This will allow the *copayment amounts* to be prorated based on the synchronized days' supply. For questions about this process, please call Member Services at the number listed at the back of your *member* identification card.

**Split-Fill Dispensing Program**
You are limited to 15-*day* supplies for the first 90 *days* when starting new therapy using certain medications (like oral oncology). You pay half the 30-*day cost share* for a 15-*day* supply, and would be responsible for the other half of the 30-*day cost share* for each additional 15-*day* supply. After 90 *days*, you will fill your medications for 30-*day* supplies.

**Lock-In Program**
To help decrease opioid overutilization 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 medications(s) only at 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.

**Oral Cancer Drugs**
We will provide oral cancer drugs at no less favorable terms than intravenously administered or injected cancer medications.

Non-Covered Services and *Exclusion*s:
No benefits will be paid under this benefit provision for services provided or expenses incurred:

1. For immunization agents otherwise not required by the Affordable Care Act.
2. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
3. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. For weight loss *prescription drugs*, unless otherwise listed on the formulary;
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
9. For more than a 30-*day* supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-*day* supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-*day* supply when dispensed by retail or mail order. **Note:** Only the 90-*day* supply is subject to the discounted *cost sharing* mail orders less than 90 *days* are subject to the standard *cost sharing* amount.
10. 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.
11. For any drug that we identify as therapeutic duplication through the Drug *Utilization Review* program.
12. For drugs or dosage amounts determined by Ambetter Pharmacy and Therapy committee 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.
13. Foreign Prescription Medications, except those associated with an *emergency* medical condition while you are travelling outside the United States. These *exceptions* apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
15. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status.
16. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
17. For any injectable medication or biological product that is not expected to be self-administered by the *member* or *member's* place of *residence* unless listed on the formulary.
18. Medication refills where a *member* has more than 15 *days*' supply of medication on hand.
19. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
20. For any drug related to dental restorative treatment or treatment of chronic periodontitis where drug administration occurs at dental practitioner's office.
21. For any drug related to *surrogate pregnancy*.
22. For medications used for cosmetic purposes.
23. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless such treatment is listed on the formulary.

24. 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 for out of country travel.

**Step Therapy Protocol**

We will base our clinical review criteria employing step therapy protocols on clinical practice guidelines that:

1. Recommend that the *prescription drugs* subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;
2. are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:
    a. requiring *members* to: 1) disclose any potential conflicts of interest with carriers, insurers, health care plans, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and
    b. using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;
3. are based on high-quality studies, research and medical practice;
4. are created pursuant to an explicit and transparent process that:
    a. minimizes bias and conflicts of interest;
    b. explains the relationship between treatment options and outcomes;
    c. rates the quality of the evidence supporting recommendations; and
    d. considers relevant patient subgroups and preferences; and
5. take into account the needs of atypical patient populations and diagnoses.

In the absence of clinical guidelines that meet the requirements above, peer-reviewed publications may be substituted. Our Pharmacy and Therapeutics committee will review and approve all such protocols.

You or your prescriber have the right to request exception to step therapy protocol.

**Prescription Drug Exception Process**

Standard exception request

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

Expedited exception request

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

External exception request review

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

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

## Preventive Care Expense Benefits

*Preventive care* expenses will not be limited based on an individual's sex assigned at birth, gender identity or recorded gender. Coverage and claims will not be denied or limited or subject to additional *cost sharing* or other *limitation*s or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

*Preventive care* services are covered as required by the Affordable Care Act (ACA). According to the ACA, *preventive care* services must include the following:

- 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 (USPSTF).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children and adolescents, evidence-informed *preventive care* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, such additional *preventive care* and screenings as provided for in comprehensive guidelines supported by the HRSA.

*Preventive care* benefits obtained from a *network* provider are covered without *member cost share* (i.e., covered in full without *deductible amount*, *copayment amount* or *coinsurance amount*). For current information regarding available *preventive care* benefits, please access the Federal Government's website at: www.healthcare.gov/coverage/preventive-care-benefits/.

*Preventive care* refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. *Preventive care* includes, but is not limited to, immunizations, medications, tobacco cessation treatment, examinations and screening tests tailored to an individual's age, health and family history.

Certain services can be performed for preventive or diagnostic reasons (e.g., mammograms). If a service is deemed *preventive care* and is appropriately reported/billed, it will be covered under the *preventive care* services benefit. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate *cost share* will apply. **Note:** If preventive and diagnostic services are performed during the same visit, applicable *cost share* will be

taken for the latter.

As new *preventive care* recommendations and guidelines are issued (by the USPSTF, CDC or HRSA), those services will become covered *preventive care* benefits. According to the ACA, coverage of new recommendations and guidelines become effective upon a plan's start or anniversary date that is one year after the date the recommendation or guideline is issued.

**Note:** In addition to providing coverage in accordance with the ACA, we also provide *preventive care* benefits in accordance with applicable State law.

Covered *preventive care* services include, but are not limited to:

- Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;
- Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese;
- Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a ≥10 percent 10-year cvd risk;
- Asymptomatic Bacteriuria in Adults: Screening: pregnant persons;
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation;
- Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer;
- Breast Cancer: Screening: women aged 40 and older;
- Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children;
- Cervical Cancer: Screening: women aged 21 to 65 years;
- Colorectal Cancer: Screening: adults aged 45 to 75 years;
- Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
- Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
- Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;
- Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;
- Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of *pregnancy*;
- Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation;
- Chlamydia and Gonorrhea: Screening: sexually active women;
- Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling: adults who are overweight or obese and have additional cvd risk factors;
- Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;
- Hepatitis B Virus Infection: Screening, 2014: persons at high risk for infection;
- Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
- Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
- Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
- High Blood Pressure in Adults: Screening: adults aged 18 years or older;
- Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
- Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
- Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality from Preeclampsia: Preventive Medication: pregnant women who are at high risk for preeclampsia;
- Lung Cancer: Screening: adults aged 55-80, with a history of smoking;
- Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;

- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
- Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
- Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
- Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
- Preeclampsia: Screening: pregnant woman;
- Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
- Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women;
- Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
- Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults;
- Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children;
- Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10 percent or greater;
- Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
- Syphilis Infection in Pregnant Women: Screening: pregnant women;
- Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
- Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women;
- Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
- Unhealthy Drug Use: Screening: adults age 18 years or older;
- Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years;
- Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults;
- Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
- Coverage for prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.

**Clinical Trial Coverage**

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

- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any *member* in the trial.

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

- Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
- The insured is enrolled in the clinical trial. This section shall not apply to insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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

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

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

**Colorectal Cancer Examinations and Laboratory Tests**
*Covered services* include colorectal cancer tests for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines. *Covered services* include tests for *members* who are at least 45 years of age; or less than 45 years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

**Cytological Screening**
*Covered services* include one annual cytologic screening test for a *member* beginning at age 18.

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

**Infertility Treatment**
Infertility services are limited to diagnostic tests and services to treat the underlying medical condition that may cause infertility (e.g., endometriosis, obstructed fallopian tubes and hormone deficiency).

*Exclusions*: Any services related to artificial insemination and any cost in connection with the collection, preparation, storage of sperm for artificial insemination, including donor fees. Any services related to conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT). Reversal of voluntary sterilization *surgery*. *Surrogate* parenting. Infertility medications, including oral infertility drugs.

**Maternity Care**
Coverage for outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *deductible amounts, copayment amounts* or *coinsurance amounts*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been *authorized* by your participating health care provider.

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 services* incurred for a shorter stay if the attending provider (e.g., your *physician*, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

**Note:** This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered services* for maternity care.

1. Give birth in a *hospital* or other health care *facility*
2. Remain under *inpatient* care in a *hospital* or other health care *facility* for any fixed term following the birth of a child

**Note:** This provision does not amend the *policy* 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 section.

**Duty to Cooperate**
We do not *cover* services or supplies related to a *member*'s *pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *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* to Ambetter from Western Sky Community Care, Inc. at Member Services, 5300 Homestead Road NE Albuquerque, NM 87110. 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.

**Newborn Charges**
*Medically necessary* services, including *hospital* services, are provided for a covered newborn child immediately after birth. *Covered services* include well baby visits and care. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*deductible amount, copayment amount*, *coinsurance amount*, and *maximum out-of-pocket amount*), as listed in the *Summary of Benefits and Coverage (SBC)*. Please refer to the Dependent Member Coverage section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

**Medical Foods**
We cover medical foods and formulas for outpatient total parenteral nutritional therapy; nutritional counseling when prescribed by a *network medical practitioner*/provider and administered by enteral tube feedings; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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

**Newborns' and Mothers' Health Protection Act Statement of Rights**
Health Insurance Issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain *authorization* from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Prostate Specific Antigen Testing**
*Covered services* include an annual digital rectal examination and prostate specific antigen tests performed to determine the level of prostate specific antigen in the blood for a *member* who is at least 50 years of age; and at least once annually for a *member* who is less than 50 years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

**Covered Preventive Services for Women and Pregnant Women include:**
1. Breastfeeding comprehensive support and counseling from trained *providers*, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
2. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
3. Domestic and interpersonal violence screening and counseling for all *members*;
4. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
5. Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists, or its successor organization;
6. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
7. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
8. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
9. Human papillomavirus vaccine for females ages 9 to 14;
10. Screenings and counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling;
11. Pregnancy related diagnostic tests, including an alpha-fetoprotein IV screening test generally between 16 to 20 weeks of *pregnancy*, to screen for certain abnormalities in the fetus;

12. Sterilization services for women only; and
13. Well-woman visits to obtain recommended preventive services.

## Radiology, Imaging and Other Diagnostic Testing

*Medically necessary* radiology services, imaging and tests performed for diagnostic reasons are a *covered service* (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), mammogram, ultrasound, Artery calcification testing). *Prior authorization* may be required, see your *Summary of Benefits and Coverage (SBC)* for details. **Note:** Depending on the service performed, two bills may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

## 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 *illness* or *injury* 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 *participating provider* listed in the Provider Directory. If a *member* chooses a *participating 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 additional *cost sharing*.

## Sleep Studies

Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required.

**Note:** A sleep study can be performed either at home or in a *facility*.

## Smoking Cessation Counseling/Program

*Coverage* is provided for diagnostic services, smoking cessation counseling and pharmacotherapy. Medical services are provided by licensed health care professionals with specific training in managing a smoking cessation program. The program shall include:

- Individual counseling under the medical benefit.
- Group counseling, including classes or a telephone quit line.

Pharmacotherapy benefit *limitations* are limited to two 90-*day* courses of treatment per *calendar year*. This plan does not cover: hypnotherapy for smoking cessation counseling, over-the-counter (OTC) drugs and acupuncture for smoking cessation.

There is no *member cost sharing* requirements for smoking cessation prescriptions, including but not limited to:

- Nicotine Gum
- Nicotine Patches
- Nicotine Lozenges
- Nicotine oral or nasal spray
- Nicotine inhaler
- Bupropion
- Varenicline

## 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 *policy*. 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 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 *policy* 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 our websites. *Members* may receive notifications about available benefits and services through emails and/or 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.WesternSkyCommunityCare.com or by contacting Member Services at 1-833-945-2029 (TTY 711).

## Telehealth Service Benefits

*Telehealth* services are covered for medical *outpatient services* and *mental health disorder* and *substance use disorder outpatient services*. *Telehealth* services are covered on the same basis and to the same extent that we would otherwise provide coverage for the same service when provided through an in-person consultation or contact and the type of setting where these services are provided is not limited. An in-person consultation or contact is not required for coverage of *telehealth services* unless the consulting telemedicine provider deems it necessary.

## Transplant Expense Benefits

*Covered Services* for Transplant Service Expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with this *policy*. *Prior authorization* must be obtained through the *"Center of Ex*cellence", a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy, before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

*Cost share* benefit coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *policy* will be provided for both you and the donor. In this case, payments made for the donor will be charged against *member's* benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *policy* will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

If we determine that a *member* and donor are an appropriate candidate for a *medically necessary transplant,* live donation, *covered services* benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).

4. Including outpatient *covered services* related to the transplant *surgery*, pre- transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy and services are performed at a *facility*.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement *limitation*s. (https://ambetter.westernskycommunitycare.com/resources/handbooks-forms.html)

These medical expenses are covered to the extent that the benefits remain and are available under the *member's policy,* after benefits for the *member's* own expenses have been paid. In the event of such coverage, the otherwise existing coverage of a live donor shall be secondary to the benefits under the *member's policy*.

Ancillary and Facility Service Benefits:
A *member* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy:

1. We will pay for the following services when the *member* is required to travel more than 75 miles from the *residence* to the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy:
2. We will pay for *member* out of pocket costs related to *transplant* service(s) for the following:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy in the United States.
    b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant *facility*, and to and from the donor's home to the transplant *facility*, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant *member* and/or donor.
    f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.WesternSkyCommunityCare.com.

Covered Transplant Expense Benefits:
Benefits will be provided or paid under these Transplant Expense Benefits:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Pancreas
7. Intestine
8. Multi-visceral (3 or more abdominal organs)
9. Simultaneous multi-organ transplant – unless investigational
10. Pancreas islet cell infusion
11. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.
12. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
7. 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 (FDA) regulation, regardless of whether the trial is subject to FDA oversight.

8. The acquisition cost for the organ or bone marrow, when provided at an un*authorized facility* or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *policy*:
    a. Alcohol/tobacco.
    b. Car rental (unless pre-approved by *case management*).
    c. Vehicle maintenance for motorized, hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.).
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    g. Speeding tickets.
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.).
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion.
    k. Expenses for lodging when *member* is staying with a relative.
    l. Any expense not supported by a receipt.
    m. Upgrades to first class travel (air, bus, and train).
    n. Personal care items (e.g., shampoo, deodorant, clothes).
    o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck, and early check-in boarding fees, extra baggage fees.
    p. Souvenirs (e.g., t-shirts, sweatshirts, toys).
    q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
    r. All other items not described in the *policy* as *eligible expenses.*
    s. Any fuel costs/charging station fees for electric cars.

Organ Transplant Medication Notification
At least 60 *days* prior to making any formulary change that alters the terms of coverage for a patient receiving *immunosuppressant drugs* or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, we must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or guardian if the patient is a child, or the *spouse* of a patient who is authorized to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an *appeal*, and include information regarding the procedure for the prescribing *physician* to initiate the *policy's appeal* process.

As an alternative to providing written notice, we may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing *physician* may initiate an *appeal*, and include information regarding the procedure for the prescribing *physician* to initiate the *policy's appeal* process.

At the time a patient requests a refill of the immunosuppressant drug, we may provide the patient with the written notification required above along with a 60-*day* supply of the immunosuppressant drug under the same terms as previously allowed.

Limitations on Transplant Service Expense Benefits:
In addition to the *exclusions* and *limitations* specified elsewhere in this section:
1. *Covered services* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.

2. If a designated *Center of Excellence* is not used, *covered services* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

## Wellness Program Benefits

Value-added service benefits may be available to *members* for participating in certain programs that we may make available in connection with this *policy*, such as "My Health Pays". Such programs may include wellness programs, disease or *case management* programs, including management for; asthma, heart disease, diabetes and pregnancy. These programs may include a reward or an incentive, which you may earn by completing different activities.

If you have a medical condition that may prohibit you from participating in these programs, we may require you to provide verification, such as an affirming statement from your *physician*, that your medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program, in order for you to receive the reward or incentive.

You may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services by telephone at 1-833-945-2029 (TTY 711). The Value-Added Service 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 *enrollees* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *enrollees*. The programs and benefits available at any given time are made part of this *policy* by this reference and are subject to change by us through updates available on our website or by contacting us.

*Enrollees* can earn rewards for focusing on their total health. The "My Health Pays" *member* rewards program may offer rewards when *enrollees* participate in activities focused on eating right, move more, saving smart and living well. *Members* may have the opportunity to earn rewards for completing activities in the following categories:

| Behavior/Action | Notes |
|---|---|
| Program Activation and Onboarding | Rewards for activating and onboarding onto the program |
| Online Activities (Power ups and Challenges) | Frequent online activities providing educational content and calls to action focused on targeted wellness behaviors and healthy living |
| Clinical Activities | Clinical activities focused on *health management*, including recommended preventive screenings and disease management participation |

Earned rewards may be used to shop for items at the online *My Health Pays* rewards store or may be converted into dollars, spent on health care related items applied towards *social determinants of health*. **Note:** New Mexico insurance law does not permit *enrollees* to apply earned rewards towards *premiums* or *cost sharing*.

Rewards for participating in a wellness program are available to all *members*. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward through an alternative means. *Members* should contact Member Services by telephone at 1-833-945-2029 (TTY 711) so they can work with you (and, if you wish, with your doctor) to find a wellness program that offers the same reward and is right for you in light of your health.

## Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. Our *care management* services can help with complex medical or *behavioral health* needs. If you qualify for *care management*, we will partner you with a care manager. Care managers are registered nurses or social workers that are specially trained to help you:

- Better understand and manage your health conditions
- Coordinate services
- Locate community resources

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will with you, your *PCP* and other *providers* to develop a care plan that meet your needs and your caregiver's needs. If you think you could benefit from our *care management* program, please call Member Services at 1-833-945-2029 (TTY 711).

# General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Any services performed for a *member* by a *member's immediate family.*
3. Any services not identified and included as *covered services* under the *policy*. You will be fully responsible for payment for any services that are not *covered services.*
4. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
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*, bariatric *surgery* and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For non-therapeutic abortion.
5. For expenses for television, telephone, or expenses for other persons.
6. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
7. For failure to keep a scheduled appointment.
8. For stand-by availability of a *medical practitioner* when no treatment is rendered.
9. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
10. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child or *surgeries* or *medically necessary* health care services related to gender affirming care and the treatment of gender dysphoria.
11. For diagnosis or treatment of learning disabilities.
12. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
13. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
14. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
15. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
16. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
17. For hearing aids, except as expressly provided in this *policy*.
18. 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.

19. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive *days*. If travel extends beyond 90 consecutive *days*, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 *days*.
20. For services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any *deductible amount* under your employer's workers' compensation coverage. This plan does not cover any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of *injury*, timely filing of claims, and medical treatment authorization.
21. For fetal reduction *surgery*.
22. Except as specifically identified as a *covered services* under the *policy*, services or expenses for alternative treatments, including acupressure, 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.
23. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
24. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
25. 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.
26. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; routine foot care except when related to diabetes, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*, except for *covered services* which have received *prior authorization*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
27. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
28. For any non-medically necessary court ordered care for a medical/surgical or *mental health disorder*/*substance use disorder* diagnosis, unless required by state law;
29. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, we have a right of recovery for any benefits paid in excess.
30. *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*.

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 insureds possessing an active *policy* with us and/ or the child possesses an active *policy* with us at the time of birth.

31. For any medicinal and recreational use of cannabis or marijuana.
32. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
33. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
34. For expenses, services, and treatments from a Naprapathic *specialist* for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
35. For expenses, services, and treatments from a Naturopathic *specialist* for treatment of prevention, self-healing and use of natural therapies.
36. For expenses, services, and treatments related to private duty nursing in an *inpatient*, outpatient or home location.
37. For expenses for services related to dry needling.
38. For the treatment of infertility, except as expressly provided in this *policy*.

**Note:** This *policy* does not include pediatric *dental services* as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent or the New Mexico Health Insurance Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

**Limitations on Benefits for Services Provided by Medicare Opt-Out Practitioners**

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

# Termination

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. On the day when there is a material failure to abide by the rules, policies or procedures of this *policy*; or fraud or material misrepresentation affecting *coverage*. For example, if a *member* knowingly gave false material information in connection with the eligibility or enrollment of the *subscriber* or any of the eligible family *members*, we may terminate the *coverage* of the *subscriber* or any eligible family *members* retroactively to the date of initial enrollment. The *subscriber* is liable for any benefit payments made as a result of such improper actions.
3. The date we receive a request from you to terminate this *policy,* or any later date stated in your request, or if you are enrolled through the New Mexico Health Insurance Exchange (Exchange), the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
4. The date we decline to renew this *policy,* as stated in the Discontinuance provision;
5. The date of your death, if this *policy* is an individual plan;
6. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*; or
7. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Exchange.

We shall provide you with 30 *days* advance written notice, prior to the termination of this *policy*.

**Note:** Should you believe that we canceled your coverage due to health status or health care requirement, race, gender, age or sexual orientation, you may submit an appeal of the termination to the Office of Superintendent.

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

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

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

180-Day Notice: If we discontinue offering all individual policies in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at least 180 *days* prior to the date that we stop offering and terminate all existing individual policies in the individual market in the state where you reside.

# Right of Reimbursement

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

If this plan provides benefits under this *policy* to a *member* for expenses incurred due to *third party* injuries, then Western Sky Community Care, Inc. retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the *third party* injuries. Western Sky Community Care, Inc.'s rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

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

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. To give Western Sky Community Care, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *Third Party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Western Sky Community Care, Inc. as reimbursement for the full cost of all benefits associated with *Third Party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
6. That we:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.

c. Will have the right to intervene in any suit or legal action to protect our rights.
d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
e. May assert the right of reimbursement independently of the *member*.

7. To take no action that prejudices our reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
8. To sign, date, and deliver to us any documents we request that protect our reimbursement rights.
9. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.
10. To reimburse us from any money received from any *third party*, to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That we may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse us.

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

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

If a dispute arises as to the amount a *member* must reimburse us, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved.

# Coordination of Benefits

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

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

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

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

"Plan", as used in this section, is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group *HMO* insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
3. Plan includes *hospital*, medical, and surgical benefits coverage of *Medicare* or a governmental plan offered, required, or provided by law, except Medicaid.
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
5. Plan does not include Individual or Family: Insurance contracts, direct payment *subscriber* contracts, coverage through *health maintenance organizations (HMO's)* or coverage under other prepayment, group practice and individual practice plans.
6. Plan whose benefits are by law excess to any private benefits coverage.

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

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

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

**Order of Benefit Determination Rules**

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

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987, which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.

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

3. If the person receiving benefits is the *member* and is only covered as an *eligible dependent* under the *other plan*, this *policy* will be primary.
4. Subject to State Statues: Social Security Act of 1965, as amended makes *Medicare* secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    a. The plan of the parent who has custody will be primary.
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
6. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

**Effects of Coordination**

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

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

# Claims

**Notice of Claim**
We must receive notice of claim within 30 *days* of the date the *loss* began or as soon as reasonably possible. Upon receipt of a notice of claim, we will provide you with the forms required to submit *proof of loss* within 15 *days*. If we have not provided the forms within this timeframe, the claim shall be deemed to have complied with the requirements of this *policy* as to *proof of loss*. upon submitting, within the time fixed in the policy for filing proof 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 member* had no legal capacity to submit such proof during that year.

**How to Submit a Claim**
*Providers* will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for *covered services*. This usually happens if:

- Your provider is not contracted with us
- You have an out-of-area emergency.

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your *deductible amount*, *copayment amount* or *cost sharing* to reimburse you.

To request reimbursement for a *covered service*, you need a copy of the detailed claim from your provider. You also need to submit a copy of the reimbursement claim form posted at Ambetter.WesternSkyCommunityCare.com under "For Members-Forms and Materials" Send all the documentation to us at the following address:

Ambetter from Western Sky Community Care
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

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

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

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

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

**Time for Payment of Claims**
*Claims* payable for any *loss* other than which we provide any periodic payment will be paid immediately upon receipt of due written proof of such *loss*. Subject to due written *proof of loss*, all accrued *claims* for *loss* for which we provide periodic payment will be paid not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims**
Except as set forth in this provision, all benefits are payable to you. Any accrued benefits unpaid at your death, or your *dependent member's* death may, at our option, be paid either to the beneficiary or to the estate. If any benefit is payable to your or your *dependent member's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, we may pay up to $1,000 to any relative who, in our opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by us in good faith under this provision shall fully discharge our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

**Foreign Claims Incurred for Emergency Care**
Medical *emergency care* is a *covered service* while traveling for up to a maximum of 90 consecutive *days*. If travel extends beyond 90 consecutive *days*, no benefit coverage is provided for medical emergencies for the entire period of travel including the first 90 *days*.

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, at the *member's* expense, within 180 calendar *days* from the date of service. Foreign claims must also include the applicable *medical records* in English or with an English translation, at the *member's* expense to show proper *proof of loss* and evidence of any payment(s) to the *provider*.

Foreign claims must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at Ambetter.WesternSkyCommunityCare.com.

The amount of reimbursement will be based on the following:
- *Member's* benefit plan and *member* eligibility on date of service.
- *Member's* responsibility/share of cost based on date of service.
- Currency rate at the time of completed transaction, foreign country currency to United States currency.

Once we have reviewed all the necessary documentation and the emergency claim has been processed, a *member* Explanation of Benefits (EOB) will be mailed. The EOB will identify *member* responsibility according to the *member* benefit plan at the time of travel. If services are deemed as a true medical emergency, the *member* will be issued reimbursement payment for any eligible incurred costs, minus *member cost share* obligation.

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

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

**Medicaid Reimbursement**
The amount provided or payable under this *policy* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives. We will pay the New Mexico Human Services Department ("HSD") any indemnity benefits payable by us on behalf of a *member* when:

1. HSD has paid or is paying benefits on behalf of the *member* under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
2. Payment for the services in question has been made by HSD to the Medicaid provider; and
3. We are notified that the *member* receives benefits under the Medicaid program and that the indemnity benefits payable by us must be paid directly to HSD (the notice may be accomplished through an attachment to the *claim* by HSD for the indemnity benefits when the *claim* is first submitted by HSD to us).

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

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

Upon request by the custodial parent, we will:

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

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

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

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

**Change of Beneficiary**
Unless you make an irrevocable designation of beneficiary, you have the right to change your beneficiary at any time and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this *policy* or to any change of beneficiary or beneficiaries or to any other changes in this *policy*.

# Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of an Ambetter decision. You will be provided with detailed information and *complaint* forms by Ambetter at each step. In addition, you can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau (MHCB)** page found under the **Departments** tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy of the regulations in one of two ways:

1. Send a request in writing to Ambetter at: Ambetter from Western Sky Community Care, Inc.
   Att: appeals and Grievances Department
   PO Box 10341
   Van Nuys, CA 91410
   Member Services: 1-833-945-2029 (TTY 711)
   Fax: 1-833-886-7956
   Web address: Ambetter.WesternSkyCommunityCare.com
   Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM
2. From the OSI by calling 1-505 827-4601 or toll free at
   1-833-415-0566

**What types of decisions can be reviewed?**

You may request a review of two different types of decisions:

**Adverse Determination:** You may request a review if Ambetter has denied pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (We must notify you before terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the *appeal* process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be *experimental*, *investigational*, or not *medically necessary* or appropriate. It may also include a denial by Ambetter of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called "***adverse determinations***."

**Administrative Decision:** You may also request a review if you object to how Ambetter handles other matters, such as our administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

## Review of an Adverse Determination

**How does pre-authorization for a health care service work?**

When Ambetter receives a request to pre-authorize (certify) payment for a health care service (service) or a request to reimburse your health care *provider* (*provider*) for a service that you have already had, it follows a two-step process.

**Coverage:** First, we determine whether the requested service is covered under the terms of your health benefits plan (*policy*). For example, if your *policy* excludes payment for adult hearing aids, then we will not agree to pay for you to have them even if you have a clear need for them.

**Medical necessity:** Next, if Ambetter finds that the requested service is covered by the *policy*, Ambetter determines, in consultation with a *physician*, whether a requested service is *medically necessary*. The consulting *physician* determines medical necessity either after consultation with *specialists* who are experts in the area or after application of uniform standards used by Ambetter. For example, if you have a crippling hand *injury* that could be corrected by plastic *surgery* and you are also requesting that Ambetter pay for cosmetic plastic *surgery* to

give you a more attractive nose, Ambetter might certify the first request to repair your hand and deny the second, because it is not *medically necessary*.

Depending on terms of your *policy*, Ambetter might also deny certification if the service you are requesting is outside the scope of your *policy*. For example, if your *policy* does not pay for *experimental* procedures, and the service you are requesting is classified as *experimental*, Ambetter may deny certification. Ambetter might also deny certification if a procedure that your *provider* has requested is not recognized as a standard treatment for the condition being treated.

**IMPORTANT:** If Ambetter determines that it will not certify your request for services, you may still go forward with the treatment or procedure. **However,** you will be responsible for paying the *provider* yourself for the services.

**What if I need services in a hurry?**
**Urgent care situation:** An ***urgent care situation*** is a situation in which a decision from Ambetter is needed quickly because:

1. Delay would jeopardize your life or health;
2. Delay would jeopardize your ability to regain maximum function;
3. The *physician* with knowledge of your medical condition **reasonably** requests an expedited decision;
4. The *physician* with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or
5. The medical demands of your case require an expedited decision.

If you are facing an *urgent care situation* **or** Ambetter has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your *provider* may request an expedited review and Ambetter must either certify or deny the initial request quickly.

If you are dissatisfied with Ambetter's initial expedited decision in an *urgent care situation*, you may then request an **expedited review** of Ambetter's decision by both Ambetter and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, Ambetter must review its prior decision and respond to your request within 72 hours. If you request that an IRO perform an expedited review simultaneously with Ambetter's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

**IMPORTANT: If you are facing an *emergency*, you should seek medical care immediately and then notify Ambetter as soon as possible. Ambetter will guide you through the claims process once the *emergency* has passed.**

**If my initial request is denied, how can I appeal this decision?**
If your initial request for services is denied or you are dissatisfied with the way Ambetter handles an administrative matter, you will receive a detailed written description of the *grievance* procedures from Ambetter as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your *policy*. Ambetter provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact Member Services as follows:

Telephone: 1-833-945-2029
Address: Ambetter from Western Sky Community Care Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
FAX # : 1-833-751-0895
Email : Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:
Telephone: 1-(505) 827-4601 or toll free at 1-(833) 415-0566
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mailto:mhcb.grievance@state.nm.us

**Who can request a review?**
A review may be requested by you as the patient, your *provider*, or someone that you select to act on your behalf. The patient may be the actual *subscriber* or a dependent who receives coverage through the *subscriber*. The person requesting the review is called the **"grievant."**

**Appealing an adverse determination – first level review**
If you are dissatisfied with the initial decision by Ambetter, you have the right to request that Ambetter's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your *policy*, may choose to contact a *specialist* or the *provider* who has requested the service on your behalf, or may rely on Ambetter's standards or generally recognized standards.

**Time limit for requesting a review**
You must notify Ambetter that you wish to request an internal review within **180 *days*** after the date you are notified that the initial request has been denied.

**What you need to provide**
If you request that Ambetter review its decision, we will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

## How Long a First Level Review Takes

**Expedited review.** If a review request involves an *urgent care situation*, Ambetter must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

**Standard review.** Ambetter must complete both the medical director's review and (if you then request it) Ambetter's internal panel review within 30 *days* after receipt of your pre-service request for review or within 60 *days* if you have already received the service. The medical director's review generally takes only a few days.

**What to do if the Medical Director denies your request**
If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by Ambetter or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by Ambetter's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your health *provider* may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

**IMPORTANT: If you are covered under the NM State Health Care Purchasing Act, you may NOT request an IRO review if** you **skip the panel review.**

**How long you have to make a decision**
If you wish to have your request reviewed by Ambetter's panel, you must inform us within 5 *days* after you receive the medical director's decision. If you wish to skip Ambetter's panel review and have your matter, go directly to the IRO, you must inform OSI of your decision within 4 months after you receive the medical director's decision.

**What happens during an Ambetter panel review?**
If you request that Ambetter provide a panel to review its decision, Ambetter will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because Ambetter felt the requested services were not *medically necessary*, were *experimental* or were *investigational*, then the panel will include at least one *specialist* with specific training or experience with the requested services.

Ambetter will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that Ambetter will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical *provider* may also attend in person or by telephone, may address the panel, or send a written statement.

Ambetter's internal panel must complete its review within 30 *days* following your original request for an internal review of a request for pre-certification or within 60 *days* following your original request if you have already received the services. You will be notified within 1 *day* after the panel decision. If you fail to provide records or other information that Ambetter needs to complete the review, you will be given an opportunity to provide the missing items, but the review process may take much longer and you will be forced to wait for a decision.

**Hint:** If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 *days*.

**If you choose to have your request reviewed by the Ambetter panel, can you still request the IRO review?**
Yes. If your request has been reviewed by Ambetter's panel and you are still dissatisfied with the decision, you will have **4 months** to request a review by an IRO.

**What's an IRO and what does it do?**
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must

assign reviewers who have no prior knowledge of the case and who have no close association with Ambetter or with you. The reviewer will consider all of the information that is provided by Ambetter and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your *provider*, Ambetter, and to OSI. Ambetter must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then Ambetter must provide them.

The IRO's fees are billed directly to Ambetter – there is no charge to you for this service.

**How long does an IRO review take?**
The IRO must complete the review and report back within 20 *days* after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an *urgent care* matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

**Review by the Superintendent of Insurance**
If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation. The co-hearing officers will provide a recommendation to the Superintendent within 30 *days* after the hearing is complete. The Superintendent will then issue a final order.

**There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to Ambetter. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.**

## Review of an Administrative Decision

**How long do I have to decide if I want to appeal and how do I start the process?**
If you are dissatisfied with an initial administrative decision made by Ambetter, you have a right to request an internal review within **180 *days*** after the date you are notified of the decision. Ambetter will notify you within 3 *days* after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

**How long does an internal review of an Administrative Decision take?**
Ambetter will mail a decision to you within 30 *days* after receiving your request for a review of an administrative decision.

**Can I appeal the decision from the internal reviewer?**
Yes. You have **20 *days*** to request that Ambetter form a committee to reconsider its administrative decision.

**What does the reconsideration committee do? How long does it take?**
When Ambetter receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 *days* after Ambetter receives your request. You will be notified at least 5 *days* prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by Ambetter, you may request that the committee hearing be postponed for up to 30 *days*.

The reconsideration committee will mail its decision to you within 7 *days* after the hearing.

**How can I request an external review?**
If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 *days*** after you receive the written decision from Ambetter. You may submit the request to OSI using forms that are provided by Ambetter. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at 1-(505) 827-4601 or toll free at 1-(833)-415-0566.

**How does the external review work?**
Upon receipt of your request, the Superintendent will request that both you and Ambetter submit information for consideration. Ambetter has 5 *days* to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and Ambetter and issue a final decision within 45 *days*. If you need extra time to gather information, you may request an extension of up to 90 *days*. Any extension will cause the review process and decision to take more time.

## General Information

**Confidentiality**
Any person who comes into contact with your personal health care records and/or genetic information must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the *provider* and Ambetter cannot release your records, even to OSI, until you have signed a release.

**Special needs and cultural and linguistic diversity**
Information about the *grievance* procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

**Reporting requirements**
Insurers are required to provide an annual report to the Superintendent with details about the number of *grievances* it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

**The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.**

# General Provisions

**Entire Policy**
This *policy,* with the enrollment application, the *Summary of Benefits and Coverage* and any amendments and/or riders (if applicable) is the entire *policy* between you and us*.* No agent may:

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

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

**Rescissions**
Any act, practice, or omission that constitutes fraud, or any intentional fraud or material misrepresentation of facts made by or on behalf of anyone seeking *coverage* under this Plan, may result in the cancellation of your coverage (and/or your *family member(s) coverage*) retroactive to the *effective date*, subject to 30 *days*' prior notification. No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

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

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

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

**Personal Health Information**
Your health information is personal. We are committed to do everything we can to protect it. Your privacy is also important to us. We have policies and procedures in place to protect your health records.

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://Ambetter.WesternSkyCommunityCare.com/privacy-practices.html or call Member Services at 1-866-263-8134 (TTY 1-855-868-4945).

We protect all of your PHI. We follow HIPAA to keep your health care information private.

**Language**
If you do not speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: https://Ambetter.WesternSkyCommunityCare.com/language-assistance.html.

**Physical Examination and Autopsy**
Ambetter from Western Sky, at its own expense, shall have the right and opportunity to examine the person of a *member* when and as often as it may reasonably require during the pendency of a *claim* hereunder and to make an autopsy in case of a *member*'s death where it is not forbidden by law.

## Statement of Non-Discrimination

Ambetter from Western Sky Community Care 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 Western Sky Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Western Sky Community Care:

- 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 Western Sky Community Care at 1-833-945-2029 (TTY 711).

If you believe that Ambetter from Western Sky Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances, PO Box 10341 Van Nuys CA 91410, at 1-833-945-2029 (TTY 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Western Sky Community Care 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*.

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-833-415-0566
www.osi.state.nm.us

To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit www.nmag.gov/consumer-complaint-instructions.aspx

State of New Mexico Office of the Attorney General
408 Galisteo Street
Villagra Building
Sante Fe, NM 87501
Toll Free (844) 255-9210
Phone: (505) 490-4060
Fax: (505) 490-4883

## Declaración de no discriminación

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

Ambetter de Western Sky Community Care:

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

Si necesita estos servicios, comuníquese con Ambetter de Western Sky Community Care, 1-833-945-2029 (TTY 711).

Si cree que Ambetter de Western Sky Community Care no le ha brindado estos servicios o le ha discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-945-2029 (TTY 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo, fax, o por correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Western Sky Community Care está disponible para usted. Además puede presentar un reclamo de derechos civiles al U.S. Department of Health and Human Services (Departamento de Salud y Servicios Humanos de EE.UU.), Office for Civil Rights (Oficina de Derechos Civiles) electrónicamente a través del Portal para reclamos de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o teléfono en: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

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Toll Free: 1-833-415-0566
www.osi.state.nm.us

To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit https://www.nmag.gov/consumer-complaint-instructions.aspx.
State of New Mexico Office of the Attorney General
408 Galisteo Street
Villagra Building
Sante Fe, NM 87501
Toll Free (844) 255-9210
Phone: (505) 490-4060
Fax: (505) 490-4883

**Spanish:** Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-945-2029 (TTY 711).

**Navajo:** Diné k'ehjí yánilti'go ata' hane' ná hóló dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchíjgo nich'į' ádoolnilgo bee haz'ą́ aldó' áko díí t'áá át'é t'áá jiik'e kót'éego nich'į' ąą'át'é. Kojį' hólne' 1-833-945-2029 (TTY 711)

**Vietnamese:** Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Western Sky Community Care, 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 1-833-945-2029 (TTY 711).

**German:** Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-945-2029 (TTY 711) an.

**Chinese:** 如果您，或是您正在協助的對象，有關於 Ambetter from Western Sky Community Care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 1-833-945-2029 (TTY 711)。

**Arabic:** إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Western Sky Community Care ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-945-2029 (TTY 711)

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Western Sky Community Care에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-833-945-2029 (TTY 711) 로 전화하십시오.

**Tagalog:** Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-945-2029 (TTY 711).

**Japanese:** Ambetter from Western Sky Community Careについて何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-945-2029 (TTY 711) までお電話ください。

**French:** Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-945-2029 (TTY 711).

**Italian:** Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Western Sky Community Care, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-833-945-2029 (TTY 711).

**Russian:** В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Western Sky Community Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-945-2029 (TTY 711).

**Hindi:** आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Western Sky Community Care के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-945-2029 (TTY 711) पर कॉल करें।

**Persian:** اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Western Sky Community Care دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-833-945-2029 (TTY 711) تماس بگیرید.

**Thai:** หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-945-2029 (TTY 711).