



FROM |  **silversummit
healthplan**

2023 Evidence of Coverage



Ambetter.SilverSummitHealthplan.com

Ambetter from SilverSummit Healthplan, Inc.

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

Major Medical Expense Insurance Policy

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

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this *policy* in the following events: (1) non-payment of premium; (3) a *member* fails to pay any *deductible* or *copayment amount* owed to us and not the provider of services; (4) a *member* is found to be in material breach of this *policy*; or (5) a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

Annually, we may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members*, type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

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

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

provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization section.

TEN DAY RIGHT TO RETURN POLICY

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

Silver Summit Healthplan, Inc.

A handwritten signature in dark ink, appearing to read "Eric Schmacker", is centered on the page.

Eric R. Schmacker
Plan President and CEO

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Introduction

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

It describes:

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

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

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

How to Contact Us

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

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

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

TTY line: **1-855-868-4945**

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

Emergency: **911**

24/7 Nurse Advice Line **1-866-263-8134** or for the hard of hearing TTY **1-855-868-4945**

Interpreter Services

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

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

To arrange for interpretation services, please call Member Services at 1-866-263-8134 or for the hard of hearing (TTY 1-855-868-4945).

Member Rights and Responsibilities

We are committed to:

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

If you have difficulty locating a *primary care physician (PCP)*, *specialist physician*, *hospital* or other contracted provider please contact us so we can assist you with accessing or 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. Providers you may see while hospitalized may not be a contracted provider with Ambetter. It is your responsibility to ensure the provider you are seen by is a contracted provider. You can access the online directory at Ambetter.SilverSummitHealthplan.com.

You have the right to:

1. Participate with your *physician* and *medical practitioners* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network of physicians, medical practitioners, hospitals*, other facilities and your rights and responsibilities.
7. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician (PCP)* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician (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.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
10. See your medical records.
11. Be kept informed of *covered* and non-covered services, program changes, how to access services, *primary care physician (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.
12. A current list of *network providers*.
 13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
 14. 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.
 15. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
 16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
 17. 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.
 18. Select your *primary care physician (PCP)* within the *network*. You also have the right to change your *primary care physician (PCP)* or request information on *network providers* close to your home or work.
 19. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *primary care physician (PCP)*.
 20. An interpreter when you do not speak or understand the language of the area.
 21. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options
 22. Make advance directives for health care decisions. This includes planning treatment before you need it.
 23. 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 Advance directives forms. Advance directive forms are forms you can complete to protect your rights for medical care. It can help your *primary care physician (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.

You have the responsibility to:

1. Read this entire *policy*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health 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 *primary care physician (PCP)*. You should establish a relationship

with your *physician*. You may change your *primary care physician (PCP)* verbally or in writing by contacting 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 *primary care physician (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 *primary care physician (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 the entity with which you enrolled.
13. Pay your monthly premiums, *deductible amounts*, *copayment amounts* or *coinsurance amounts* on time.
14. Verify any provider seen, including providers seen while hospitalized, are contracted providers.
15. 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 *network providers* is available online at Ambetter.SilverSummitHealthplan.com. We have plan *physicians, hospitals*, and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network providers* by completing the “Find a Provider” function on our website and selecting the Ambetter *network*. There you will have the ability to narrow your search by provider specialty, zip code, gender, 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 list of providers near you at no charge by calling Member Services at 1-866-263-8134 (TTY: 1-855-868-4945). In order to obtain benefits, you must designate a *network primary care physician (PCP)* for each *member*. We can help you pick a *primary care physician (PCP)*. We can make your choice of *primary care physician (PCP)* effective on the next business day.

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

Member Identification Card

We will mail you a *member* identification card after we receive 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 1-866-263-8134 (TTY: 1-855-868-4945). We will send you another card. A temporary *member* identification card can be downloaded from Ambetter.SilverSummitHealthplan.com.

Website

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

1. Finding a *network provider*, 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, makes 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* and *copayment* accumulators.
9. Selecting a *primary care physician (PCP)*.

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 the 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 *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

For example, if you have a concern about the care you received from your *network physician* or service provided by us, please contact 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-network 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 *network hospital* or at a *network* health care facility if the *member* did not give informed consent or *prior authorization* to be seen by the *non-network 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 receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation* services must be performed for three or more hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. *Advance 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 the 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.

Adverse benefit determination means a decision by us which results in:

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

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

Allowed amount (also see *Eligible expense*) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *member's* benefits. This amount excludes agreed to amounts between the provider and us as a result of Federal or State Arbitration.

Note: If you receive services from a *non-network provider*, you may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that we pay. 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-network 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-network provider* or *non-network facility* for *emergency services* or air ambulance services. See *balance billing* and *non-network 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.SilverSummitHealthplan/health-plans/our-benefits/ambetter-telehealth.html.

Appeal means any request for an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant to reverse, rescind or otherwise modify any *adverse benefit determination* concerning, but not limited to, any of the following:

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

Applicable laws mean laws of the state in which your *policy* was issued and/or federal laws.

Applied behavior analysis or **ABA** is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. *ABA* has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury.

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

Authorization or **authorized** means our decision to approve the medical necessity or the appropriateness of care for a *member* by the *member's PCP* or provider.

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

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

Autism spectrum disorder means a 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-network provider* billing you for the difference between the *provider's* charge for a service and the *eligible expense*. *Network providers* may not balance bill you for *covered service expenses* beyond your applicable *cost sharing* amounts. If you are ever balanced billed contact Member Services immediately at the number on the back of your *member* identification card.

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

Behavioral health means both *mental health disorder* 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.

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* provider.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *medically necessary* transplants or other services such as cancer; bariatric or infertility; and
2. Has agreed with us or an entity designated by us to meet quality of care criteria on a cost-efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

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

Complaint means an oral 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 that is resolved in 24 hours of making the *complaint*.

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*.

Continuing care patient means an individual who, with respect to a provider or facility, is (i) undergoing a treatment for a *serious and complex condition* from that provider or facility; (ii) is undergoing a course of institutional or *inpatient* care from that provider or facility; (iii) is scheduled to undergo non-elective *surgery* from that provider, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the *pregnancy*; or (v) is determined to be *terminally ill* and is receiving treatment for such *illness*.

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

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

Cost share or cost sharing means the *deductible amount, copayment amount, and coinsurance* that you pay for *covered services*. The *cost sharing* amount that you are required to pay for each type of *covered service* is listed in the *Schedule of Benefits*. When you receive *covered services* from a *non-network provider* in a *network facility*, or when you receive *covered emergency services* or air ambulance services from *non-network providers*, *cost sharing* may be based on an amount different from the *allowed amount*.

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

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. *Members* of a federally recognized American Indian tribe and/or an Alaskan Native may qualify for additional *cost sharing reductions*.

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

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

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

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

Deductible or deductible amount means the amount that you must pay in a *calendar year* for *covered service expenses* before we will pay benefits. For family coverage, there is a family *deductible amount* which

is two times the individual *deductible amount*. Both the individual and the family *deductible amounts* are shown in the *Schedule of Benefits*.

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

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

If you satisfy your individual *deductible amount*, each of the other *members* of your family are still responsible for their *deductible* 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 the primary *subscriber's* lawful *spouse*, *domestic partner* or an *eligible child*. Each *dependent member* must either be named in the enrollment application or we must agree in writing to add them as a *dependent member*.

Domestic partner means persons who:

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

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

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

Eligible child means the child of a 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 that 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* as determined below.

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by Federal or Nevada law, the *eligible expense* is as follows:
 - a. When a covered *emergency service* is received from a *non-network provider* within Nevada, the *eligible expense* depends on the provider's status:

Emergency Services from Non-Network Hospitals and Free-Standing ERs (Provider Facilities)

If, within the 12 months immediately preceding the provision of *medically necessary emergency services* to a *member*, the *non-network hospital* or independent center for emergency medical care had a contract as a *network hospital* or independent center for emergency medical care with us, we will pay (and the *hospital* or independent center for emergency medical care will accept), 108 percent of the amount that would have been paid for those services under the most recent contract between us and the *hospital* or independent center for emergency medical care.

If the *non-network hospital* or independent center for emergency medical care had a contract as a *network hospital* or independent center for emergency medical care with us within the 24 months immediately preceding the provision of *medically necessary emergency services* to a *member*, but not within the 12 months immediately preceding the provision of the *medically necessary emergency services*, we will pay (and the *hospital* or independent center for emergency medical care will accept), 115 percent of the amount that would have been paid for those services under the most recent contract between us and the *hospital* or independent center for emergency medical care.

If a *non-network hospital* or independent center for emergency medical care did not have a contract with us as a *network hospital* or independent center for emergency medical care during that time, we will pay to the *provider* an amount that we have determined to be fair and reasonable as payment for the *medically necessary emergency services*. The terms do not apply to critical access *hospitals* and persons covered by a policy of insurance sold outside of Nevada.

Non-Network Providers (Excluding facilities) of Emergency Services

If, within the 12 months immediately preceding the provision of *medically necessary emergency services* to a *member*, a *non-network provider* had a contract as a *network provider* with us that that was not terminated by us for cause, we will pay (and the provider to accept), an amount based on the amount that would have been paid for those services under the most recent contract between us and the provider.

If a *non-network provider* did not have a contract with us that provides coverage for the *member* as a *network provider* during that time or if we terminated such a contract for cause, we will pay to the provider an amount that we have determined to be fair and reasonable as payment for the *medically necessary emergency services*.

If the billing entity does not accept a payment made as payment in full for the *medically necessary emergency services*, the *non-network provider* will request from us an additional amount which, when combined with the amount previously paid, the *non-network provider* is willing to accept as payment in full and, if not paid, the parties will submit the dispute to binding arbitration. The terms do not apply to critical access *hospitals* and persons covered by a policy of insurance sold outside Nevada.

Note: You may not be billed for the difference between the *allowed amount* paid and the *non-network provider's charge*.

- b. When a covered *emergency service* is received from a *non-network provider* outside of Nevada, 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 service* is received from a *non-network* 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 reimbursement as determined by us and as required by *applicable law*. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you will not be *balance billed* for the difference between the *allowed amount* and the *provider's* charges, but you may be subject to *cost sharing* obligations. *Member cost share* will be calculated from the recognized amount based upon *applicable law*. 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.
 - e. For all other *covered services* received from a *non-network 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 will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with us, the *eligible expense* is the greatest of the following: (1) the amount that would be paid under Medicare, or (2) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; and (3) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. In addition to applicable *cost sharing*, you may be *balance billed* for these services.

Emergency services (medical, *behavioral health*, and *substance use disorder*) means covered *inpatient* and *outpatient services* 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 manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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;
4. Serious harm to self or others due to an alcohol or drug use emergency; or
5. *Injury* to self or bodily harm to others; or with respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another *hospital* before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Services you receive from a *non-network provider* or *non-network 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. You must notify us or verify that your *physician* has notified us of your admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *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 more than 24 hours after you have been *medically stabilized* is no longer considered *emergency* care. Continuation of care from a *non-network provider* beyond what is 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*.

Enhanced direct enrollment (EDE) means an Ambetter tool that allows you to apply for coverage, renew and report life changes entirely on our website without being redirected to the Exchange. If you have utilized enroll.ambetterhealth.com to apply or renew, a consumer dashboard has been created for you. You can log into your consumer dashboard at enroll.ambetterhealth.com.

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 a FDA-approved drug is a use that is determined by us to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*; or

- d. It has FDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the provider's research protocols.

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

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

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

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

Generally accepted standards of medical practice means 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 dissatisfaction about anything other than an *adverse benefit determination*. *Grievances* may refer to any dissatisfaction about, but are not limited to:

- a) Us, as the insurer (e.g., customer service *grievances* - "the person to whom I spoke on the phone was rude to me");
- b) Providers with whom we have a direct or indirect contract;
- c) Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
- d) Quality of care/quality of service issues.

Habilitation or habilitation services means health care services that help 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.

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

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

1. Provided by a *home health care agency*; and

2. Prescribed and supervised by a *physician*.

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

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

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

Hospice means 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 an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility*, or *residential treatment facility*, halfway house, or transitional facility, or a patient is moved from the emergency room in a short-term observation status, a *member* will be deemed not to be confined in a *hospital* for purposes of this policy.

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

Immediate family means the parents, *spouse*, *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.

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 percentage of covered expenses*, as shown in the *Schedule of Benefits*.

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

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

Medically necessary means our decision as to whether any medical service, supply, item or treatment to diagnose and treat a *member's illness* or *injury*:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an outpatient.

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

Medically stabilized for non-emergency services means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*. Stabilize, with respect to an *emergency* medical condition, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer* to a *network* facility or discharge of the individual from a facility, (*See Ambulance Service Benefits provision under the Major Medical Expense Benefits section).

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's 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 *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

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

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

Network provider(s) means any licensed person or entity that has entered into a contract with Ambetter from SilverSummit Healthplan to provide *covered services* to *members* enrolled under this *policy* including but not limited to, *hospitals*, *specialty hospitals*, *urgent care centers*, *physicians*, pharmacies, laboratories and other health professionals within our *service area*.

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-network provider means a *medical practitioner*, *provider facility* or other provider who is NOT identified in the most current list for the *network* shown on your identification card. Services received from a *non-network provider* are not covered, except for:

1. *Emergency services*, as described in the *Major Medical Expense Benefits* section of this *policy*;
2. Non-emergency health care services received at a *network* facility, as described in the **Access to Care** section of this *policy*; or
3. Situations otherwise specifically described in this *policy*.

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

Other valid coverage 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, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, government programs or workers' compensation and Medicare when the *member* is enrolled in Medicare. *Other valid coverage* will not include Medicaid.

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

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

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* as issued and delivered to you. It includes the attached pages, the *Schedule of Benefits*, the enrollment application and any amendments and/or riders.

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

Pre-service claim means any claim for benefits for medical care or treatment that has not been provided and requires the approval by us in advance of the claimant obtaining the medical care.

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

Prescription drug means any 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 *Schedule of Benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *covered persons' eligible expenses*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

Serious and complex condition means, in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic *illness* or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

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

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

Spouse means the person to whom you are lawfully married.

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).

Surgery or surgical procedure means:

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

Surrogacy/gestational carrier arrangement means an understanding in which a woman (the *surrogate/gestational carrier*) 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/gestational carrier* receives payment for acting as a *surrogate/gestational carrier*.

Surrogate/gestational carrier means an individual who, as part of a *surrogacy/gestational carrier 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.

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

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

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

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

Tobacco or nicotine use or use of tobacco or nicotine means *use of tobacco* or *nicotine* by individuals who may legally *use nicotine or 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 center means a facility, not including a *hospital* emergency room or a *physician's* office, that provides treatment or services that are required:

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

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

Dependent Member Coverage

Dependent Member Eligibility

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

1. The date you became covered under this *policy*;
2. The date of marriage to add a *spouse*;
3. The date of 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; or
6. The date a domestic partnership is established, pursuant to state law.

Effective Date for Initial Dependent Members

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 enrolled with (either the Exchange or us). Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

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 from the entity you enrolled with (either the Exchange or us) of the child's birth.

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and we have received notification from the 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.

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 member* and you pay the required premiums, we will send you written confirmation of the added *dependent member's effective date* of coverage and *member* identification cards for the added *dependent members*.

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 of termination that the Exchange provides us upon your request of cancellation to the Exchange, or if you enrolled directly with us, the date we receive a request from you to terminate this *policy*, or any later date stated in your request;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *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 at least 30 days after the notice is delivered or mailed to the *member*: 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 Exchange at www.nevadahealthlink.com. If you enrolled through Ambetter, you can contact Member Services at 1-866-263-8134 (TTY 1-855-868-4945).

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 31st day of December the year the dependent turns 26 years of age.

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 Member Services at 1-866-263-8134 (TTY 1-855-868-4945) or the Exchange at 1-800-547-2927 (TTY 711).

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 31, 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 directly to the Exchange or by using Ambetter's *Enhanced Direct Enrollment* tool, 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 *member's* unborn child, or medically needed coverage;

2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, or placement for adoption of a *member* or their *spouse*, placement in foster care, or a child support order or other court order;
 - a. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1;
 - b. For one or more days during the 60 days preceding the date of marriage;
 - c. In the case of a parent being required by an order for medical coverage for a child and the parent is eligible for coverage of *members* of the family, the parent is allowed to enroll the child in coverage without any regard to any restrictions upon enrollment periods.
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 Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. A *member* 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 *member'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 change in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or *member* 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;
 - a. The qualifying events for employees are:
 - i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
 - ii. Reduction in the number of hours of employment.
 - b. The qualifying events for *spouses* are:
 - i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
 - ii. Reduction in the hours worked by the covered employee;
 - iii. Covered employee's becoming entitled to Medicare;
 - iv. Divorce or legal separation of the covered employee; or
 - v. Death of the covered employee.
 - c. The qualifying events for dependent children are the same as for the *spouse* with one addition:
 - i. Loss of dependent child status under the plan rules.
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month; or
11. A *qualified individual* or *member* 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* or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid; or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event or

14. At the option of the Exchange, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a *qualified health plan* through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

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.

A *qualified individual* newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

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*.

Non-Silver State Health Insurance Exchange Plan Enrollment

You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance Exchange is the only way to receive financial assistance for your health insurance. You can enroll online by visiting www.nevadahealthlink.com or by calling 1-800-547-2927 TTY 711.

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

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

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-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 HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing

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.

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the 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 and Limited Enrollment 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* enrollment 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 medical and *behavioral health covered service expenses* require *prior authorization*. In general, *network providers* must obtain *authorization* from us prior to providing a service or supply to a *member*. However, there are some *network eligible expenses* for which you must obtain the *prior authorization*.

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

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

Prior authorization (medical and *behavioral health*) requests must be received by phone/eFax/provider portal as follows:

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

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

1. For urgent concurrent reviews within 24 hours (one calendar day) of receipt of the request.
2. For urgent *pre-service* reviews, within 72 hours (three calendar days) from date of receipt of request.
3. For non-urgent *pre-service* reviews within 15 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 *network 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 will result in benefits being reduced or not covered.

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

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

Prior Authorization Does Not Guarantee Benefits

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

Denied Prior Authorization

Refer to the Appeal and Grievance Procedures section of this *policy* for information on your right to *appeal* a denied *authorization*.

Requests for Predeterminations

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

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

We will make all benefit determinations after a loss in good faith. All benefit determinations are subject to our receipt of proper *proof of loss*.

Services from Non-Network Providers

Except for *emergency* medical services, we do not normally cover services received from *non-network providers*. If a situation arises where *covered services* cannot be obtained from a *network provider* located within a reasonable distance, we may provide a *prior authorization* for you to obtain the service from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or your *PCP* must request *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

Cost Sharing Features

Cost Sharing Features

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

When you, or a covered dependent, receive health care services from a provider, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or provider to create a condition or *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 this *policy* and in your *Schedule of Benefits*.

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amount* does not include any *copayment amount* or *coinsurance amount*. Not all *covered service expenses* are subject to the *deductible amount*. See your *Schedule of Benefits* for more details.

Copayments

A *copayment* is typically a fixed dollar amount due at the time of service. *Members* may be required to pay *copayments* to a provider each time services are performed that require a *copayment*. *Copayments*, as shown in the *Schedule of Benefits*, 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. *Copayments* 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 amount* in addition to any applicable *deductible amount(s)* due for a *covered service* or supply. *Coinsurance amounts* do not apply toward the *deductible*, but do apply toward your *maximum out-of-pocket amount*.

Maximum Out-of-Pocket

You must pay any required *copayments* or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. 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 *members' eligible expenses*.

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-network provider*. Please refer to the information in your *Schedule of Benefits*.

The applicable *deductible amount(s)*, *copayment amounts* and *coinsurance amounts* are shown on your *Schedule of Benefits*.

Non-Network Liability and Balance Billing

If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network 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 *network* costs for the same service and might not count toward your annual *maximum out-of-pocket amount* limit.

When receiving care at a *network* facility, it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *network 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-network providers* should not bill you for *covered services* for any amount greater than your applicable *network cost sharing* responsibilities when:

1. You receive a covered *emergency service* or air ambulance service from a *non-network provider*. This includes services you may get after you are in stable condition, unless the *non-network 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-network provider* at a *network hospital* or *network ambulatory surgical facility*.
3. You receive other non-emergency services from a *non-network provider* at a *network hospital* or *network ambulatory surgical facility*, unless the *non-network provider* obtains your written consent.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a special tax-exempt custodial account or trust owned by a *member* where contributions to the account may be used to pay for current and future qualified medical expenses. Please refer to your *Schedule of Benefits* to see if the plan you are enrolled in has an HSA. For *members* enrolled in an HSA compatible plan, the following terms apply.

Individual *members* must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA.

This Evidence of Coverage is administered by Ambetter from SilverSummit Healthplan and underwritten by SilverSummit Healthplan. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. SilverSummit Healthplan, its designee and its affiliates, including Ambetter from SilverSummit Healthplan, do not provide tax, investment or legal advice to *members*.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERNING HSA MAXIMUM ALLOWABLE AMOUNT, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH MEMBER WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

Access to Care

Primary Care Physician (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
- Pediatricians (for children)

*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 *Schedule of Benefits* for more information.

You may obtain a list of *network PCPs* at our website and using the “Find a Provider” function 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. You may be required to obtain a referral from your *PCP* in order to receive care from a *specialist provider*. You do not need a referral from your *network PCP* for *emergency care* services, mental or *behavioral health* services or services from an obstetrician/gynecologist. You may seek services from a *network* obstetrician/gynecologist, a *behavioral health* or *substance use disorder provider* directly without a written *referral*.

Changing Your Primary Care Physician (PCP)

You may change your *network PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at Ambetter.SilverSummitHealthplan.com, 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 Physician (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 to cancel or change your appointment, call 24 hours in advance. If you need help, call Member Services at 1-866-263-8134 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 1-877-687-1180 (TTY 1-877-941-9231). 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.

Network Availability

The *network* is subject to change upon advance written notice. A *network service area* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving or as soon as possible. **Note:** *Covered services* received from *non-network providers* are not *covered services* under this *policy* but you may have the opportunity to disenroll from coverage under this *policy* and enroll in a different health plan with a *network* in that area. If you receive non-emergency services from *non-network providers*, benefits will be calculated in accordance with the terms of this *policy* for *non-network providers*.

Coverage Under Other Policy Provisions

Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *policy*.

Non-Emergency Services

If you are traveling outside of the Nevada *service area*, you may be able to access providers in another state if there is an Ambetter plan located in that state. You can locate Ambetter *providers* outside of Nevada by searching the relevant state in our Provider Directory at guide.ambetterhealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter *provider* outside of the *service area*, you may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on your *member* identification card for further information.

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. You do not need prior approval for emergency care services.

Hospital Based Providers

When receiving care at a *network hospital* it is possible that some hospital-based *providers* (for example, assistant surgeons, hospitalists and intensivists) may not be under contract with us as *network 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-network provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

You may not be balance 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-network provider* at a *network hospital* or *network* ambulatory facility.

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 *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 receive care from that *provider* as a *network* benefit beginning on the date on which the above notice is provided and ending the later of (i) 120 days after the date the contract is terminated or (ii) if the *member* is pregnant, then 45 days after the date of delivery or if the *pregnancy* does not end in delivery, the date the of the end of the *pregnancy*.

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.

Preferred Partnership

As innovative technologies and solutions are established in market under expedited research and development, we may elect to offer, at our discretion, new services or preferred partnerships designed to improve access to care and enhance *care management*. Ambetter will provide access to *third party* services at preferred or discounted rate. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

Major Medical Expense Benefits

The plan provides coverage for health care services for a *member* and/or dependents. Some services require preauthorization. *Copayment amounts, deductibles, and coinsurance* must be paid to your *network provider* at the time you receive services.

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

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

Benefit Limitations

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

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 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 with 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

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

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses, injuries, congenital birth defects, or complications of premature birth* that require that level of care.

3. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by Ambetter SilverSummit Health Plan.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

Note: Unless otherwise required by Federal or Nevada 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 air ambulance services for transportation for fixed wing and rotary wing air transportation from home, scene of accident or medical *emergency*.

Benefits for air ambulance services are limited to:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in cases of *emergency*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses, injuries, congenital birth defects, or complications of premature birth* that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a skilled nursing, *rehabilitation facility* and *member's* home when *authorized* by Ambetter from SilverSummit Health Plan.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

Limitations: 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.

Note: Non-emergency ambulance transportation requires *prior authorization*.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency medical transportation.
3. Air medical transportation:
 - 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.

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

- Evaluation and assessment services;
- *Applied behavior analysis* therapy;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy;
- *Behavioral health* services 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*.

No limitation exists within the benefits for *applied behavior analysis* services. 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* and/or *coinsurance* will apply to each provider.

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, examinations including podiatric examinations; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management (limited to one visit per episode), eye examinations, and prescription medication; and one retinopathy examination screening per year.

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

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

Chiropractic Services

Chiropractic services are covered when a *network* chiropractor finds that the services are *medically necessary* to treat or diagnose Neuromusculoskeletal Disorders on an outpatient basis. *Covered service expenses* are subject to all other terms and conditions of this *policy*, including *deductible amount* and *cost sharing percentage* provisions. See the *Schedule of Benefits* for benefit levels or additional 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 *network 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 of an artificial kidney machine.

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

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

The supplies, equipment, and appliances described below are *covered services* under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in your situation or needed to treat your condition, reimbursement will be based on the maximum *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/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.
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 *Schedule of Benefits* for benefit levels or additional limits.

Medical and Surgical Supplies

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

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

1. Chem strips, Glucometer, Lancets.
2. Clinitest.
3. Needles/syringes.
4. Ostomy bags and supplies, except charges such as those made by a Pharmacy for purposes of a fitting, are not *covered services*.
5. 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. Med-injectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

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

Medical Service Benefit

We provide coverage for health care services for a *member* and/or dependents. Some services require preauthorization.

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

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

Benefit Limitations:

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

Orthotic Devices

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

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. *Medically necessary* corrective footwear, *prior authorization* may be required.

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. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
2. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted (except as specified under the Medical Supplies provision above).
3. Garter belts or similar devices.

Prosthetics

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

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

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

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

1. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular 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. Cochlear implant and bone anchored hearing aids.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per *calendar year*) when purchased through a *network 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.
4. Wigs (except as described above following cancer treatment).

Family Planning and Contraception

Family planning/contraception benefits are covered under preventive care, without *cost sharing* (when provided by a *network provider*). These benefits include the following for adolescent and adult women, in accordance with the most recent guidelines supported by the Health Resources and Services Administration (HRSA):

- The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including: (1) sterilization *surgery* for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), (7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel) and (17) emergency contraception (ulipristal acetate).
- Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending *provider* have determined it to be medically appropriate).
- Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
- Instruction in fertility awareness-based methods, including lactation amenorrhea.

Note: Services that are integral to the furnishing of the above-listed preventive care coverage (e.g., anesthesia provided during sterilization *surgery* for women), are also included under preventive care, regardless of whether the service is billed separately.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be *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. Coverage for cardiac *rehabilitation*, pulmonary therapy, physical therapy, occupational therapy, and speech therapy.

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

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

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

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

Home Health Care Service Expense Benefits

Covered services and supplies for *home health care* are 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 rendered on an outpatient basis. Please refer to your *Schedule of Benefits* for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*.
4. Intravenous (I.V.) medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment*.

Intravenous (I.V.) medication and pain medication are *covered services* to the extent they would have been *covered services* during an *inpatient hospital* stay. At our option, we may *authorize* the purchase of the equipment from a *network 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.

Limitations:

See your *Schedule of Benefits* for benefit levels or additional limits for expenses related to *home health aide services*. *Home health care* services not in conjunction with a registered or licensed practical nurse and home health aide are not covered.

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

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting.

This list of *covered services* include:

1. Room and board in a *hospice* while the *member* is an *inpatient*.
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill 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*.

Benefits for *hospice inpatient*, home or outpatient care are available to a *terminally ill member* for one continuous period up to 365 days per *calendar year*. For each day the *member* is confined in a *hospice*, benefits for room and board will not exceed the most common semi-private room rate of the *hospital* or nursing home with which the *hospice* is associated.

Respite care is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a covered *member* under Hospice Care. Respite days that are applied toward the

member's cost share obligations are considered *covered services* and shall apply against any maximum benefit limit for these services. See your *Schedule of Benefits* for coverage limits. Respite services, provided as part of *hospice* care, are limited to 5 *inpatient* days/outpatient visits per 90 days.

Exclusions and Limitations:

Any exclusion or limitation contained in the *policy* regarding:

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

Hospital Benefits

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. 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 *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* 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.

Note: Some providers that treat you within the emergency room may not be contracted with us. If that is the case, they may not balance bill you for the difference between our *allowed amount* and their *billed amount*.

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.

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies.
2. For the professional services of a *medical practitioner*, including *surgery*.
3. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
4. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
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 accidental *dental service* expenses when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in damage to his or her natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
9. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and percentage provisions.
10. For oxygen and its administration.
11. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the *Schedule of Benefits* for benefit levels or additional limits.

12. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
13. For the following types of tissue transplants:
 - a. Cornea transplants.
 - b. Artery or vein grafts.
 - c. Heart valve grafts.
 - d. Skin grafts.
 - e. Prosthetic tissue replacement, including joint replacements.
 - f. Implantable prosthetic lenses, in connection with cataracts.
14. Family planning for certain professional provider contraceptive services and supplies, or its therapeutic equivalent, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices up to a 12-month supply per prescription. This also includes education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use.
15. Any type of hormone replacement therapy which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.
16. *Medically necessary services* made by a *physician* who renders services in a *network urgent care center*, including facility costs and supplies.
17. Radiology services, including X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CAT scan), Positron Emission Tomography (PET scan) and ultrasound imaging.
18. *Medically necessary and prior authorized prosthetic devices* are limited to one (1) item once every three (3) years.
19. For *medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth services* provided by *Ambetter Telehealth* vendors are subject to \$0 *copay*. *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. Pursuant to federal regulation, the \$0 *cost share* does not apply to *members* enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible.
20. Limited diagnostic and therapeutic infertility services determined to be *medically necessary* and requires *prior authorization*. *Covered services* do not include those services specifically excluded herein, but do include limited:
 - a. Laboratory studies;
 - b. Diagnostic procedures; and
 - c. Artificial insemination services, up to six (6) cycles per *member* per lifetime.
21. *Prior authorized medically necessary bariatric surgery*, and complications from bariatric surgery, for extreme obesity under the following conditions:
 - a. Have a body mass index (BMI) of greater than 40kg/m²; or
 - b. Have a BMI greater than 35kg/m² with significant co-morbidities; and
 - c. Can provide documented evidence that dietary attempts at weight control are ineffective; and
 - d. Must be at least 18 years of age.
22. For *medically necessary* genetic blood tests.
23. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
24. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
25. For *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
26. For respiratory and pulmonary therapy.
27. 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.

28. 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.

29. For *medically necessary* diagnostic and laboratory and x-ray tests;

30. For *medically necessary* nutritional counseling, *prior authorization* may be required.

31. For *medically necessary* routine foot care, *prior authorization* may be required.

32. 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;

33. For pulse oximetry screening on a newborn;

34. 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 Care Expense Benefits** provision for a list of well child/well baby services.

35. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

36. Allergy testing, injections and serum.

37. 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;

38. Cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Coverage is limited to a maximum cost of \$75 per transplant.

39. 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.

40. Testing of pregnant women and other *members* for lead poisoning.

Mental Health and Substance Use Disorder Benefits

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

If you need mental health or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* and *substance use* provider *network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network Behavioral health* providers by using our Find a Provider tool at Ambetter.SilverSummitHealthplan.com or by calling Member Services at 1-866-263-8134 (TTY 1-855-868-4945). *Deductible amounts, copayment, or coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and *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* Utilization Management staff utilizes Change Healthcare 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 and/or *substance use disorder* services are as follows:

Inpatient

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. *Inpatient* rehabilitation;
4. Crisis stabilization;
5. *Residential treatment facility* for mental health and *substance use disorders*; and
6. Electroconvulsive therapy (ECT).

Outpatient

1. Partial hospitalization program (PHP);
2. Intensive *outpatient* program (IOP);
3. Mental health day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and *substance use disorders*;
6. Individual and group therapy for mental health and *substance use disorders*;
7. Medication assisted Treatment- combines behavioral therapy and medications to treat *substance use disorders*;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis* for the treatment of *autism spectrum disorders*;
11. Telemedicine;
12. Electroconvulsive therapy (ECT);
13. *Transcranial magnetic stimulation (TMS)*; and
14. Assertive community treatment (ACT).

Behavioral health covered services are only for the diagnosis or treatment of mental health conditions and the treatment of *substance use disorders*.

Expenses for these services are covered, if *medically necessary* and may be subject to *prior authorization*. Please see the *Schedule of Benefits* for more information regarding services that require *prior authorization* and specific benefit 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 1-866-263-8134 (TTY 1-855-868-4945) to be referred to a care manager for an assessment.

Other Dental Services

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

whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

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

1. Damage to the *member's* natural teeth; and
2. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

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 jaw bone 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 five;
 - 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.
 - c. *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 *member*.
3. For four mastectomy bras per year if the *member* 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 pair of hearing aids per *covered person*. See the *Schedule of Benefits* for benefit

levels or additional limits.

Pediatric Routine Vision Benefits – Children under the age of 19

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 *Schedule of Benefits* for a detailed list of *cost sharing*, annual maximum and appropriate service limitations. To see which vision providers are part of the *network*, please visit Ambetter.SilverSummitHealthplan.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 *PCP*.

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 21 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.

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

1. A *prescription drug*.
2. Prescribed, oral anticancer medication. Self-administered oral cancer drugs are capped at \$100 per 30-day supply.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.
4. Preventative HIV drugs and oral contraceptives, covered on the formulary, will be covered regardless if a prescription is required or not, provided that appropriate pharmacy dispensing procedures are followed by a *network* pharmacy.
5. Off-label drugs that are:
 - a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
 - b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

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.

Medication Balance-On-Hand

Medication refills are prohibited until a *member's* 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.

Extended Days' Supply Process

Maintenance medications are generally taken daily for chronic and lifelong conditions. Ambetter uses Medi-Span to determine which medications are defined as maintenance medications. Extended days' supply fills of maintenance medications are available exclusively at CVS retail and CVS Mail. *Members* obtaining a 90-day fill via CVS Retail or CVS Mail will pay only 2.5 times *their* standard retail *copay*. Non-CVS pharmacies are limited to dispensing up to 30-days' supply of maintenance medications.

In-network pharmacy: Up to 30-day supply of maintenance medications and non-maintenance medications

CVS Retail: Maintenance medications with days' supply of 84-90 days
CVS Mail Order: Maintenance medications with days' supply of 31-90 days

Formulary or Prescription Drug List

The formulary or *prescription drug* list is a guide to available generic and brand name drugs and some over-the-counter medications when ordered by a *physician* 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: The formulary is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated and may be subject to change. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specified drug.

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.SilverSummitHealthplan.com (under "For Member", "Drug Coverage") or call Member Services at 1-866-263-8134 (TTY 1-855-868-4945).

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.

How to Fill a Prescription

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

If you decide to have your prescription 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.SilverSummitHealthplan.com on the Find a Provider page. 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.SilverSummitHealthplan.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/coinsurance*. 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 website. Once on our website, click on the section, "For Member," "Drug Coverage." 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*.

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

Extended Days' Supply

Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills of select maintenance medications are available exclusively at CVS Mail Order. *Members* obtaining a 90-day fill via CVS Mail Order will pay only 2.5 times their standard retail *cost sharing* amount.

Non-Covered Services and Exclusions:

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs*, unless specifically listed on the formulary.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary.
8. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *experimental or investigational* drugs.
9. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
10. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by any retail or mail order or a pharmacy other than CVS retail or CVS mail 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.
11. 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.
12. 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 document if obtained in the United States.
13. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
14. For medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. Drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless

of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.

18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
20. For any drug related to surrogate *pregnancy*.
21. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 days' supply of medication on hand, excluding early refills of topical ophthalmic products.
24. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
25. For immunization agents otherwise not required by the Affordable Care Act.

Non-Formulary Prescription Drugs

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

Lock-In Program

To help decrease 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 medication(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 lock-in program. *Members* identified for participation in 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.

Split-Fill Dispensing Program

Members are limited to 15-day supplies for the first 90 days when starting new therapy using certain medications (like oral oncology). *Members* 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, *members* will fill their medications for 30-day supplies.

Topical Ophthalmic Products

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

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

Prescription Drug Continuity of Coverage

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

Prescription Drug Synchronization

Under Nevada law, you have the right to request synchronization of your medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example, if

you fill medication A on the 5th of each month and your provider prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help you adjust your fill dates for medication B and synchronize the fill dates with medication A. We will adjust *copays* to reflect shorter or longer coverage. If you would like to exercise this right, please call our Member Services.

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. 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 Center for Disease Control and Prevention (CDC).
3. 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).

4. 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*, *coinsurance amount* or *copayment 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.

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 or phase II, III or IV for treatment of chronic fatigue syndrome. 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* starting at age 45. (**Note:** Screening should start before age 45 for high-risk individuals.)

Benefits for *covered expenses* for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques *authorized* by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of *deductible amounts*, *coinsurance* provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from *deductible amounts*, *coinsurance* provisions, and *copayment amounts*, when received from a *network provider*.

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

Cytological Screening

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

Human Papillomavirus (HPV)

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

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.

Mammography

A mammography examination, called a mammogram, aids in the early detection and diagnosis of breast cancer. Mammograms are classified as either a screening or a diagnostic mammogram, depending on the circumstances and how the procedure is billed.

Preventive mammograms are routinely administered to screen for/detect breast cancer in individuals with no apparent symptoms and are covered without *cost share* (under preventive care) as follows:

- If the individual is less than 40 years of age and at risk, we cover at least one baseline breast cancer screening mammography; thereafter, we cover one breast cancer screening mammography every year.
- If the covered person is at least 40 years of age, we cover one breast cancer screening mammography every year.

Diagnostic mammograms are more in-depth than screenings and do not fall under preventive care coverage. Diagnostic mammograms are typically for individuals with suspicious results on a screening mammogram or after some sign of breast cancer is detected. *Cost share* may apply for diagnostic mammograms, depending on the plan design.

Maternity Care

An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a *physician* or other health care provider obtain *prior authorization* for the delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the Health Plan.

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

1. Give birth in a *hospital* or other health care facility; or
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 this *policy* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates/gestational carriers* and children born from *surrogates/gestational carriers*. Please reference General Non-Covered Services and Exclusions section as limitations may exist.

Duty to Cooperate. If a *member* requires maternity services, even if acting as a *surrogate*, those maternity services shall be covered. However, *members* who are a *surrogate/gestational carrier* at the time of enrollment or *members* who agree to a *surrogacy/gestational carrier arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy/gestational carrier arrangement*, send us written notice of the *surrogacy/gestational carrier arrangement* to Silver Summit Health Plan at Member Services 2500 North Buffalo Drive, Suite 250, Las Vegas, NV 89128. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the basis of fraud, misrepresentation or false information, up to and including recoupment of all excluded benefits that we paid on behalf of the *surrogate/gestational carrier* during the time that the *surrogate/gestational carrier* was insured under our *policy*, plus interest, attorney's 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. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*copayment*, *coinsurance* percentage, *deductible* and *maximum out-of-pocket amount*), as listed in the *Schedule of Benefits*. Please refer to the Dependent Member Coverage section for details regarding Coverage for a Newborn Child/Coverage for an adopted child.

Newborns' and Mothers' Health Protection Act Statement of Rights

Health Insurance Issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not

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

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

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

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

Medical Foods

We cover medical foods and formulas for outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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

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. Screening for blood pressure abnormalities;
7. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
8. Cervical cancer screening for sexually active *members*;
9. Screening for depression;
10. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
11. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
12. *Tobacco* or *nicotine* use screening and interventions for all *members*, and expanded counseling for pregnant *tobacco* users;

13. All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, or its successor organization; and
14. Well-woman visits to obtain recommended preventive services.

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 and ultrasound). *Prior authorization* may be required, see your *Schedule of Benefits* 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 *injury* or *illness* exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable *copayment amount* 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.

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 a *Center of Excellence*, 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 the *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 to the recipient.
4. If there is a 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 service expenses* 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* 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* and services are performed at a *network 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 and mileage. Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations (Ambetter.SilverSummitHealthplan.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 "Center of Excellence" Service Benefits

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

1. 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*:
2. We will pay a maximum of \$10,000 per transplant service for the following services:
 - a. Transportation for the *member*, any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*.
 - b. When the *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* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. 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.SilverSummitHealthplan.com.

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 unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* or donor, when performed 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 the *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 the *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 pre-check, 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 the *policy's 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.

Wellness and Other Program Benefits

Benefits may be available to *members* for participating in certain programs that we may make available in connection with this *policy*. Such programs may include wellness programs, disease or *care management* programs. 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.SilverSummitHealthplan.com or by contacting Member Services at 1-866-263-8134 (TTY: 1-855-868-4945). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *policy* by this reference and are subject to change by us through updates available on our website or by contacting us.

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 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.SilverSummitHealthplan.com or by contacting Member Services at 1-866-263-8134 (TTY 1-855-868-4945).

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 1-866-263-8134 (TTY 1-855-868-4945).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of the *member's immediate family*.
4. Any services not identified and included as *covered service expenses* under the *policy*. You will be fully responsible for payment for any services that are not *covered service expenses*.
5. Any non-medically necessary court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.

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

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

Covered 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*, and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-therapeutic abortion.
6. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described under the Major Medical Expense Benefits section.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations between *providers*, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Major Medical Expense Benefits section.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
13. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits provision under the Major Medical Expense Benefits section.
14. Mental health services are excluded:
 - a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
 - b. Pre-marital counseling;
 - c. Court-ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that would otherwise be covered under this *policy*;
 - d. Testing for ability, aptitude, intelligence or interest; and
 - e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
15. Services which are custodial or residential in nature.

16. Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
17. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. While confined primarily to receive *rehabilitation, custodial care*, educational care, or nursing services (unless expressly provided for in this *policy*).
19. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
20. 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*.
21. For hearing aids, except as expressly provided in this *policy*.
22. 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.
23. As a result of an *injury or illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
24. For fetal reduction *surgery*.
25. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
26. 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).
27. 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.
28. 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.
29. 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; 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*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
30. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
31. Biofeedback.
32. *Surrogacy/Gestational Carrier Arrangement*.

The following health care services, including supplies and medication to a non-covered *member* serving as a *surrogate/gestational carrier* pursuant to a *surrogacy/gestational carrier arrangement* with a *member* are excluded. This exclusion applies to all health care services, supplies and medication to the non-covered *surrogate/gestational carrier* 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/gestational carrier* following childbirth);
- d. Mental Health Services related to the *surrogacy/gestational carrier arrangement*;
- e. Expenses relating to donor semen, including collection and preparation for implantation;
- f. Donor gamete or embryos or storage relating to a *surrogacy/gestational carrier arrangement*;
- g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy/gestational carrier arrangement*;
- h. Preimplantation genetic diagnoses relating to a *surrogacy/gestational carrier arrangement*;
- i. Any complications of the *surrogate/gestational carrier* resulting from the *pregnancy*; or
- j. Any other health care services, supplies and medication relating to the *surrogacy/gestational carrier arrangement*.

Any and all health care services, supplies or medication provided to any child birthed by a *surrogate/gestational carrier* as a result of a *surrogacy/gestational carrier arrangement* are also excluded. This exclusion shall not apply, where a *member* possessing an active *policy* with us is the intended parent of the child as defined under NRS 126.590 and pursuant to NRS 126.720 and/or the child possesses an active *policy* with us at the time of birth. **Note:** We will not deny, limit or seek reimbursement for maternity care because you are acting as a *gestational carrier*.

33. For expenses for services related to dry needling.
34. For any medicinal and recreational use of cannabis or marijuana.
35. Immunizations that are not *medically necessary*. This includes those used for travel and occupational.
36. For expenses, services and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
37. 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.
38. For expenses, services, and treatments from a Naturopathic specialist for treatment of prevention, self-healing and use of natural therapies.
39. For expenses, services and treatments related to private duty nursing on an outpatient basis or home location.
40. For all health care services obtained at an *urgent care center* that is a *non-network provider*.
41. For treatment of infertility, except as expressly provided in this *policy*.

Termination

Termination of Policy

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

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

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

For coverage purchased outside the Exchange, we will reinstate a *policy* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage. For coverage purchased via the Exchange, the Exchange should be contacted for reinstatement.

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 *injuries* or *illness* to a *member*. Such *illnesses* or *injuries* are referred to as “*third party injuries*.” “Responsible party” includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of *third party injuries*.

If this plan provides benefits under this *policy* to a *member* for expenses incurred due to *third party injuries*, then SilverSummit Healthplan, Inc. retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the *third party injuries*. SilverSummit Healthplan, Inc.’s rights of recovery apply to any *other valid coverage* as defined in NRS 689A.230.

By accepting benefits under this plan, the *member* specifically acknowledges SilverSummit Healthplan, Inc.’s right of recovery. When this plan provides health care benefits for expenses incurred due to *third party injuries*, SilverSummit Healthplan, Inc. shall be included in the *member’s* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan.

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. To give SilverSummit Healthplan, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *Third Party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due SilverSummit Healthplan, Inc. as reimbursement for the full cost of all benefits associated with *Third Party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
6. That we:
 - a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
 - b. May give notice of that lien to any *third party* or *third party’s* agent or representative.
 - c. Will have the right to intervene in any suit or legal action to protect our rights.
 - d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member’s* behalf.
 - e. May assert the right of reimbursement independently of the *member*.
7. To take no action that prejudices our reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
8. To sign, date, and deliver to us any documents we request that protect our reimbursement rights.
9. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.

10. To reimburse us from any money received from any *third party*, to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That we may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse us.

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

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

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

Coordination of Benefits

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

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

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

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

"Plan", 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 *hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
3. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
4. Plan whose benefits are by law excess to any private benefits coverage.
5. Individual plans.

"Primary plan" is one whose benefits must be determined without taking the existence of any *other valid coverage* 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 valid coverage*.
2. If the *other valid coverage* does not contain a coordination of benefits provision that is consistent

with this provision then it is always primary. There are two exceptions:

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

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

3. If the person receiving benefits is the *member* and is only covered as an *eligible dependent* under the *other valid coverage*, this *policy* will be primary.
4. Subject to Federal laws: 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 valid coverage* 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 valid coverage* 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 stepparent's plan, the plan of the parent with custody will pay first, the stepparent'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 valid coverage* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
7. If the person receiving services is the *member* and is covered under a separate stand-alone dental benefit plan, that stand-alone dental benefit plan shall be primary for services provided by an oral and maxillofacial surgeon.
8. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and *other valid coverages*. 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 valid coverages* covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

Claims

Notice of Claim

We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

Proof of Loss

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

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*, *copayment* 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 *member* reimbursement claim form posted at Ambetter.SilverSummitHealthplan.com under "Member Resources." Send all the documentation to us at the following address:

Ambetter from SilverSummit Healthplan
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

Benefits will be paid within 30 days for clean claims filed electronically or on paper. "Clean claims" means a claim submitted by you or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If we have not received the information we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 20 days of our initial receipt of the claim and will complete our processing of the claim within 30 days after our receipt of all requested information.

Payment of Claims

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

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

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

Foreign Claims Incurred For Emergency Care

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.SilverSummitHealthplan.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 benefits of this *policy* to the state if:

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Legal Actions

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

No Third Party Beneficiaries

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

Appeal and Grievance Procedures

Internal Procedures

Your satisfaction is very important to us. We want to know your issues and concerns so we can improve our services. Reporting these will not affect your health care services. The following processes are available to address your concerns.

Call Member Services

Please contact Member Services at 1-866-263-8134 (TTY 1-855-868-4945) if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

Applicability/Eligibility

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

An eligible grievant is:

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

Important: *Adverse benefit determinations* that are not *grievances* will follow standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* processes.

Appeal

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Appeals will be promptly investigated and presented to the internal grievance panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. We are required to provide continued coverage pending the outcome of an *appeal*. A request for an *appeal* must be submitted within 180 days following receipt of an *adverse benefit determination*.

You or your *authorized representative* may file an *appeal* by calling Member Services at 1-866-263-8134 (TTY: 1-855-868-4945) or in writing by mailing or faxing your *appeal* to:

Claimants should submit all documentation to us at:
Ambetter from SilverSummit Healthplan
Attn: Appeals & Grievances Department
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128

Acknowledgement

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

When acknowledging a *grievance* filed by an *authorized representative*, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

1. The acknowledgement shall state that unless otherwise permitted under *applicable law*, informed consent is required and the acknowledgement shall include an informed consent form for that purpose;
2. If such disclosure is prohibited by law, health care information or medical records may be withheld from an *authorized representative*, including information contained in its resolution of the *grievance*; and
3. A *grievance* submitted by an *authorized representative* will be processed regardless of whether health care information or medical records may be disclosed to the *authorized representative* under *applicable law*.

Resolution Timeframes

All other *grievances* will be resolved and we will notify the claimant in writing with the *appeal* decision within the following timeframes:

- a. *Post-service appeal*: within 30 calendar days after receipt of the claimant's request for internal *appeal*; or
- b. *Pre-service appeal*: within 30 calendar days after receipt of the claimant's request for internal *appeal*.

The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *appeal* process 60 calendar days if we provide the claimant and the claimant's *authorized representative*, if applicable, written notification of the following within the first 30 calendar days:

- a. That we have not resolved the *appeal*;
- b. When our resolution of the *appeal* may be expected; and
- c. The reason why the additional time is needed.

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

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

Grievance Panel

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

The grievance panel will include:

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

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

Expedited Appeal

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

An *expedited appeal* shall be resolved as expeditiously as the claimant's health condition requires but not more than 72 hours after receipt of the *appeal*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, grievance panel/right to appear, and acknowledgement do not apply to *expedited appeals*.

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

Written Appeal Response

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

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

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *appeal*;
3. The signature of one voting *member* of the panel; and
4. A written description of position titles of panel *members* involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
 - a. A clear explanation of the decision;
 - b. Reference to the specific plan provision on which the determination is based;
 - c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
 - d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
 - e. If the *adverse benefit determination* is based on a medical necessity or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
 - g. The date of service;
 - h. The health care provider's name;

- i. The claim amount;
- j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- k. The health plan's denial code with corresponding meaning;
- l. A description of any standard used, if any, in denying the claim;
- m. A description of the external review procedures, if applicable;
- n. The right to bring a civil action under state or federal law;
- o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
- p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
- q. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Grievances

Basic elements of a *grievance* include:

- 1. The complainant is the claimant or an *authorized representative* of the claimant;
- 2. The submission may or may not be in writing;
- 3. The issue may refer to any dissatisfaction about:
 - a. Us, as the insurer; e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me";
 - b. Providers with whom we have a direct or indirect contract;
 - i. Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
 - ii. Quality of care/quality of service issues;
- 4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*;
- 5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints*, if resolved within 24 hours; and
- 6. Any of the issues listed as part of the definition of *grievance* received from the claimant or the claimant's *authorized representative* where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Oral quality of care or quality of service *complaints* received that are not resolved within 24 hours are handled as a *grievance*. If you make an oral *complaint* and you are not satisfied with the resolution of the *complaint*, you must file the *complaint* in writing to receive further review of the *complaint*.

You or your *authorized representative* may file a *grievance* by calling Member Services at 1-866-263-8134 (TTY: 1-855-868-4945) or in writing by mailing or faxing your *grievance* to:

SilverSummit Healthplan
 Attn: Appeal Department
 2500 North Buffalo Drive, Suite 250
 Las Vegas, NV 89128
 Phone 1-866-263-8134
 Fax Number: 1-855-742-0125

If filing a written *grievance*, please include:

- Your first and last name
- Your *member* identification number
- Your address and telephone number
- Details surrounding your concern

- Any supporting documentation

Acknowledgement

Within five (5) business days of receipt of a *grievance*, a written acknowledgment to the claimant or the claimant's *authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail.

Resolution Timeframes

Grievances regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the claimant and the claimant's *authorized representative*, if applicable, written notification of the following within the first 30 calendar days:

- That we have not resolved the *grievance*;
- When our resolution of the *grievance* may be expected; and
- The reason why the additional time is needed.

If we do not receive the required information before the end of the extension period we will resolve the *grievance* with the information we have on file.

Complaints received from the State Insurance Department

The commissioner may require us to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a claimant as a *grievance* as appropriate. We will process the State Insurance Department *complaint* as a *grievance* when the commissioner provides us with a written description of the *complaint*. *Complaints* received from the State Insurance Department are not treated as a *grievance* and only the State Insurance Department is provided the *complaint* resolution.

External Review

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

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

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

Applicability/Eligibility

The *grievance* procedures apply to:

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

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

1. The internal *appeal* process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
 - a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's

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

External review is available for *grievances* that involve:

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

External Review Process

- 1. We have five (5) business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - a. The individual was a *covered person* at the time the item or service was requested;
 - b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity *experimental or investigational*, medical judgment, or *rescission*;
 - c. The claimant has exhausted the internal process; and
 - d. The claimant has provided all of the information required to process an external review.
- 2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete;
- 3. We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification;
- 4. We will assign an IRO on a rotating basis from our list of contracted IROs;
- 5. Within five (5) business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO; **Note:** For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
- 6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
- 7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider;
- 8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;
- 9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
- 10. Within 15 calendar days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written

notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and

11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

Binding Arbitration

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

Sometimes disputes or disagreements may arise between Ambetter from SilverSummit and you (including your enrolled Dependents, heirs or personal representatives). Most disputes are those that are defined as *appeals* under the *policy*. At other times disputes or disagreements may arise regarding the construction, interpretation, performance or breach of this *Policy*, or regarding other matters relating to or arising out of your Ambetter from SilverSummit.

Appeals under the *policy* are not subject to arbitration. This is because disputes regarding *grievances* are handled and resolved exclusively through the Ambetter from SilverSummit Grievance and Complaint Procedures contained in your *policy*. This *policy* describes your rights and the process provided.

For a dispute that is not an *appeal* subject to that process, Ambetter from SilverSummit uses binding Arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Ambetter from SilverSummit involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

Ambetter from SilverSummit binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is \$200,000 or less (\$50,000 or less with respect to disputes with Ambetter from SilverSummit involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to Ambetter from SilverSummit, appoint a mutually acceptable single neutral American Arbitration Association ("AAA") arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000 or \$50,000, whichever is applicable. In the event that total amount of damages is over \$200,000 or \$50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to Ambetter from SilverSummit, appoint a mutually acceptable panel of three neutral AAA arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement on selection of the AAA arbitrator(s), the parties will follow the arbitration selection process of the AAA. The Arbitration can be initiated by submitting a demand for arbitration to Ambetter from SilverSummit at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

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

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

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

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

Appeal and Grievance Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	5 Business Days	30 Calendar Days	30 Calendar Days
Expedited Grievance	180 Calendar Days	N/A	72 Hours	N/A
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	30 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	N/A

Standard Post-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	30 Calendar Days
External Review	4 Months	N/A	15 Calendar Days	N/A
Expedited External Review	4 Months	N/A	72 Hours	N/A

General Provisions

Entire Policy

This *policy*, with the enrollment application, the *Schedule of Benefits* and any amendments and/or riders is the entire *policy* between you and us. No agent may:

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

Non-Waiver

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

Rescissions

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

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member*;
2. A copy of the enrollment 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 back to the date the misrepresentation of fact occurred 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 retroactive to the date of the fraudulent act, during the time the *member* was covered under the *policy*.

Conformity with Applicable Laws

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

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 Ambetter.SilverSummitHealthplan.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: Ambetter.SilverSummitHealthplan.com/language-assistance.html.

Statement of Non-Discrimination

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

Ambetter from SilverSummit Healthplan:

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

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

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

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



Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de SilverSummit Healthplan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-263-8134 (TTY 1-855-868-4945).
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from SilverSummit Healthplan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-263-8134 (TTY 1-855-868-4945).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from SilverSummit Healthplan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-866-263-8134 (TTY 1-855-868-4945)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from SilverSummit Healthplan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-263-8134 (TTY 1-855-868-4945) 로 전화하십시오.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from SilverSummit Healthplan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-263-8134 (TTY 1-855-868-4945).
Amharic:	እርስዎ ወይም እርስዎ የሚርዱት ሰው ስለ Ambetter from SilverSummit Healthplan ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ እስተርጓሚ ለማነጋገር በ 1-866-263-8134 (TTY 1-855-868-4945) ይደውሉ፤
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีความเกี่ยวข้องกับ Ambetter from SilverSummit Healthplan ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพทติดต่อที่หมายเลข 1-866-263-8134 (TTY 1-855-868-4945).
Japanese:	Ambetter from SilverSummit Healthplan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-866-263-8134 (TTY 1-855-868-4945) までお電話ください。
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from SilverSummit Healthplan ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-866-263-8134 (TTY 1-855-868-4945).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from SilverSummit Healthplan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-866-263-8134 (TTY 1-855-868-4945).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from SilverSummit Healthplan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-263-8134 (TTY 1-855-868-4945).
Persian:	اگر شما، یا کسی که به او کمک می کنید سوالی در مورد Ambetter from SilverSummit Healthplan دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-866-263-8134 (TTY 1-855-868-4945) تماس بگیرید.
Samoan:	'Āfai e iai ni au fesili, po'o ni fesili fo'i a se isi 'o 'e fesoasoani i ai, e uiga i le Ambetter from SilverSummit Healthplan, e iai lau āiā e sa'ili ai ni fa'amatalaga i lau lava gagana e aunoa ma se tofogi. 'A 'e fia talanoa i se fa'amatala'upu, telefoni le 1-866-263-8134 (TTY 1-855-868-4945).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from SilverSummit Healthplan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-263-8134 (TTY 1-855-868-4945) an.
Ilocano:	No dakayo, wenno ti tultulunganyo, ket addaan iti saludsod maipapan ti Ambetter from SilverSummit Healthplan, addaankayo iti karbengan nga agpatulong ken dumawat iti impormasyon a naiyulog iti lengguaheyo nga awanan ti bayad. Tapno makasarita iti tao a mangiyulog iti sabali nga lengguahe, umawag iti 1-866-263-8134 (TTY 1-855-868-4945).