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2023 Evidence of Coverage

Ambetter Core

Ambetter.NHhealthyfamilies.com

75841 NH011-2023

IMPORTANT INFORMATION

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

AMBETTER FROM NH HEALTHY FAMILIES
UNDERWRITTEN BY CELTIC INSURANCE COMPANY
Ambetter Core

Home Office: 200 E. Randolph Street, Ste. 3600 Chicago, Illinois 60601
Phone No. 1-844-265-1278
Ambetter.NHhealthyfamilies.com

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

Individual Major Medical Expense Insurance *Contract*

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

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

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

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

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing the *contract* in the following events: (1) non-payment of premium; (2) a *member* moves outside the *service area*; (3) a *member* is found to be in material breach of this *contract* ; or (4) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

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

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

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

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

Celtic Insurance Company

Kevin J. Counihan, President

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INTRODUCTION

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

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

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

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

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

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

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

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

Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a *provider's* office with you. *Members* who are blind or visually impaired and need help with interpretation can call *Member* Services for an oral interpretation.

To arrange for interpretation services, please call *Member* Services at 1-844-265-1278 or for the hard of hearing (TTY 1-855-742-0123).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as a *member*.
2. Enc*our*aging open discussions between you, and your *provider(s)*.
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, and/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 on the Ambetter contracted *hospitals*. The online directory also lists affiliations that your provider may have with non-contracted *hospitals*. Your Ambetter coverage requires you to use contracted providers with limited exceptions.

You have the right to:

1. Participate with your *providers* in decisions about your 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 practitioner*s, hospitals, other facilities and your rights and responsibilities.
7. Make recommendations regarding our member rights and responsibilities policy.
8. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your *physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
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, *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 practitioner*s 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 *physician*(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *PCP*'s instructions are not followed. You should discuss all concerns about treatment with your *PCP*. Your *PCP* can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.
18. Select your *PCP* within the *network*. You also have the right to change your *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 *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 directives forms are forms you can complete to protect your rights for medical care. They can help your *primary care physician* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for *yourself*. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney

    You should not be discriminated against for not having an advance directive.
24. Determine your own "Do Not Resuscitate" Orders

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with c*our*tesy 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 practitioner*s need 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 I.D. card and keep scheduled appointments with your *physician* and call the *physician*'s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting our Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. Provide all information about any other medical coverage you have upon enrollment in this plan. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
13. Pay your monthly premium on time and pay all *deductible amounts, copayment amounts*, or *coinsurance* at the time of service.
14. Inform the us if you have any changes to your name, address, or family members covered under this *contract* within 60 days from the date of the event. These changes can also be done by logging into your consumer dashboard on enroll.ambetterhealth.com.
15. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract*, such as: birth of a child, or adoption, marriage, divorce, adding/removing a dependent, spouse/domestic partner be-comes eligible under a different insurer, enrollment changes, or incarceration where *member* cost share would need to transfer from one *contract* to another *contract*.

    NOTE: Notify us if you have any changes to your name, address, or family members covered under this *contract.* These changes can also be done by logging into your consumer dashboard on enroll.ambetterhealth.com.

IMPORTANT INFORMATION

Provider Directory
A listing of *network providers* is available online at Ambetter.NHhealthyfamilies.com. We have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you health care services. You can find any of our *network providers* by visiting our website and using the "Find a Provider" function. There you will have the ability to narrow your search by provider specialty, zip code, gender, 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 address, phone number, office hours, specialty and board certifications.

At any time, you can request a printed copy of the provider directory at no charge by calling *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123). In order to obtain benefits, you may designate a *PCP* for each *member.* We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

Call the *PCP*'s office if you want to make an appointment. If you need help, call *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123). We will help you make the appointment.

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

The *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 1-844-265-1278, (TTY 1-855-742-0123). We will send you another card.

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

1. Finding a *network provider*, including hospitals, and pharmacies
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your *Member* identification card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news.
7. Our Formulary or Preferred Drug List.
8. Selecting a *PCP*.
9. *Deductible* and *Copayment* Accumulators.
10. Making your payment.

Quality Improvement
Our primary goal is to improve your health and help you with any *illness* or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality 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 that includes *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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 provider or facility *network* status with the health plan; or
2. Non-emergency health care services provided to a *Member* at an in-*network hospital* or at an in-*network* health care facility if the *member* did not give informed consent or *prior authorization* to be seen by the out-of-*network* provider pursuant to the federal No Surprises Act.

Please review the Access to Care and Covered Services sections of this Policy for detailed information.

DEFINITIONS

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

Wherever used in this *contract* :

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

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

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, investigational, cosmetic treatment,* not *medically necessary* or inappropriate.

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

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

Please note, if you receive services from a *non-network provider*, you may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that we pay. T However, you will not be responsible for *balance billing* for unanticipated *out-of-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.nhhealthyfamilies.com/health-plans/our-benefits/ambetter-telehealth.html.

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

Applicable Laws means laws of the state in which your contract was issued and/or federal laws.

Applied behavior analysis (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.

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.

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

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

Autism spectrum disorder (ASD) 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.

Authorization or ***Authorized*** means our decision to approve the *medically necessary* or the appropriate care for a *member* by the *member's* PCP or *provider* before the *member* receives services.

Balance billing means a *non-network provider* billing you for the difference between the provider's charge for a service and the *eligible expense*. *Network providers* may not *balance bill* you for *covered services beyond* your *applicable cost sharing amounts.*

If you *are ever balance billed contact Member Services immediately at the number listed on the back of* your *member* identification *card.*

A health care *provider* performing anesthesiology, radiology, emergency medicine, or pathology services shall not *balance bill* you for fees or amounts other than *copayments*, *deductibles*, or *coinsurance*, if the service is performed in a *hospital* or ambulatory surgical center that is in *network* under the patient's health insurance plan. This prohibition shall apply whether or not the health care provider is contracted with the patient's insurance carrier.

Behavioral health includes both mental health and *substance use disorder*, 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 is the amount a provider charges for a service.

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

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

Center of excellence means a *hospital* that:

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

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

Chiropractic services *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.*

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

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from *pregnancy* but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal pregnancy. This includes ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include false labor, preeclampsia, edema, prolonged labor, *physician* prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct *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.

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

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

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

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

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

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

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

Custodial care includes but is not limited to the following:

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

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

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

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

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

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

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

Dependent member means 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.

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.

Drug discount, ***coupon***, ***copayment card***, or manufacturer supplied prepaid credit card are typically provided by a drug manufacturer. The cards or coupons discount the copay or your other out of pocket costs (e.g., deductible, or maximum out of pocket.) to acquire a medication.

Effective date means the date a *member* becomes covered under this *contract* 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 step-child.
3. A legally adopted child.
4. A foster child placed in your custody.
5. A child placed with you for adoption; or
6. A child for whom legal guardianship has been awarded to you or your *spouse* or domestic partner.

It is your responsibility to notify us if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we pay for a child at a time when the child did not qualify as an *eligible child*.

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

1. For *network providers*: When a *covered service expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers* unless otherwise required by Federal or New Hampshire law, the *eligible expense* is as follows:
    a. When a *covered emergency service* or *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 will not be *balance billed* for the difference between the amount we pay and the provider's charges, but you may be subject to *cost-sharing* obligations. If you are balance billed in these situations, please contact *Member* Services immediately at the number listed on the back of your *member* identification card.
    b. When a *covered 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 amount we pay 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.

c. When a *covered service expense* is received from a *non-network provider* because the service or supply is not available from any *network provider* in your *service area* and is not the result of an *emergency*, the *eligible 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: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for non-*network* providers; or (iii) the contracted amount paid to *network* providers for the *covered service* (if there is more than one contracted amount with *network* providers for the *covered service*, the amount is the median of these amounts). You will not be billed for the difference between the amount paid and the provider's charge.

d. For all other *covered services* received from a *non-network provider* for which 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: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network* providers; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). In addition to applicable *cost-sharing*, you may be *balance billed* for these services.

Emergency services means health care services that are provided to an enrollee, insured, or subscriber in a licensed *hospital* emergency facility by a provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could be expected to result in any of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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.

Enhanced direct enrollment (EDE) means an Ambetter tool that allows you to apply for coverage, renew and report life changes entirely on our website. 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*; and
3. A *physician* with knowledge of the *claimant's* medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

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

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

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

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

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

incompetent.

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 that are based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service expense* under the *contract*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

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

Habilitation or ***Habilitation Services/Therapy*** 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.

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

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

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

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

Home health aide services means those services provided by a home health aide employed by a *home 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 standards of medical practice for the *injury* or *illness* requiring the *home health care.*

Hospice refers to services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by your attending *physician* or *primary care 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*.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family.*

Hospital means an institution that:

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

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

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

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

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

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

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

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

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

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

Maximum out-of-pocket amount means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), copayment amount, and coinsurance percentage of *covered services*, as shown in the *Schedule of benefits*.

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

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

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

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

5. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment.

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

Medically stabilized 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.

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

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

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

Naturopathic medicine means a system of primary health care practiced by doctors of *naturopathic medicine* for the prevention, diagnosis, and treatment of human health conditions, injuries, and diseases that uses education, natural medicines and therapies to support and stimulate the individual's intrinsic self-healing processes

Naturopathic physician means a person authorized and licensed to practice *naturopathic medicine*

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 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 *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 NH Healthy Families to provide covered services to *members* enrolled under this *contract* including but not limited to, hospitals, specialty hospitals, Urgent Care facilities, *physicians*, pharmacies, laboratories, and other health professionals within our *service area*.

Non-elective caesarean section means:

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

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

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

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

Other plan means any plan or contract that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

Other practitioner as used in your *Schedule of benefits* and related to Mental Health/*Substance Use Disorder* services, refers to a mental health or *substance use disorder* provider licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

Outpatient means services that include facility, ancillary, and professional charges when given as an *Outpatient* at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the plan. These facilities may include a non-*Hospital* site providing Diagnostic and therapy services, surgery, or *rehabilitation*, or other *provider facility* as determined by us. Professional charges only include services billed by a *Physician* or other professional.

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

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

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

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

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

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

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires 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 services*, 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 *member* 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 *members*' *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 (PCP) means a *physician* who gives or directs health care services for you. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), *physician* assistants (PA), obstetrician gynecologist (ob-gyn), internists, and pediatricians or any other practice allowed by the *contract*. A PCP supervises, directs, and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

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

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

Provider facility means a *hospital, rehabilitation facility*, 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 45 CFR 156-part C issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in 45 CFR 155, part K.

Qualified individual means an individual who has been determined eligible to enroll *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 cardiac therapy, *rehabilitation therapy,* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

Rehabilitation 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.

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

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

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

Rehabilitation licensed practitioner means, but is not limited to, a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

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

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

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

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

Service area means a geographical area, made up of counties, where we have been *authorized* by the State of New Hampshire to sell and market our health plans. This is where the majority of our *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 our Member Services.

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.

Self-injectable drugs 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.

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

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

Spouse means the person to whom you are lawfully married.

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

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

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

Surrogate means an individual gestational carrier who, as part of a *surrogacy arrangement*, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier 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 contract under which the *member* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit our right to recover from these sources.

Tobacco 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 *contract* 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) is a non-invasive procedure in which a changing magnetic field is used to cause electric current to flow in a small, targeted region of the brain via electromagnetic induction.

Unproven service(s) means services, including medications that are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

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

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

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, 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 Eligibility
Your *dependent members* become eligible for insurance on the latter of:

1. The date you became covered under this *contract.*
2. The date of marriage to add a spouse.
3. The date of an eligible newborn's birth; or
4. The date that an adopted child is placed with a *member* for the purposes of adoption or a *member* 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 Dependents
Members included in the initial enrollment application for this *contract* will be covered on your *effective date*.

Coverage for a Newborn Child
An *eligible child* born to a covered person will be covered from the time of birth until the 31st day after its birth without payment of additional premium or enrollment of the newborn. However, for coverage to be extended beyond 31 days as specified herein, you are required to (A) notify us of the addition of the newborn to your policy and (B) make a premium payment for coverage beginning on day 32 for the newborn child. Failure to provide timely notice and premium payment as provided herein will result in the newborn child's coverage terminating on day 31 after its birth.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to us 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 given by you within 60 days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth unless we have received notice by you of the child's birth.

Coverage for an Adopted Child
An *eligible child* legally placed for adoption with a *member* 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. For coverage to be extended beyond 31 days as specified herein, you are required to (A) notify us of the addition of the placed child to your *contract* and (B) make a premium payment for coverage beginning on day 32 for the legally placed child as provided herein. Failure to provide timely notice and premium payment as provided herein will result in the child's coverage terminating on day 31 tolled from the date of *placement*. The child will be covered on the same basis as any other *dependent*.

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

Notice of the adoption or birth of a child must be given to us directly within the 31-day timeframe.

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

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 our *Member* Services department at 1-844-265-1278 or you can log onto your Ambetter *member* portal to process these changes. You can log onto your consumer dashboard at enroll.ambetterhealth.com to process these changes.

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

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

ONGOING ELIGIBILITY

Open Enrollment
There will be an open enrollment period for coverage. The Open Enrollment period begins November 1, 2022, and extends through January 15, 2023. *Qualified Individuals* who enroll prior to December 15, 2022, will have an *effective date* of coverage on January 1, 2023.

Special and Limited Enrollment
In general, a *qualified individual* has 60 days to report certain life changes, known as "qualifying events," to us or by using *Ambetter's Enhanced Direct Enrollment Tool*. *Qualified Individuals* may be granted a *Special Enrollment Period* where they may enroll in or change to a different plan during the current plan year if they have a qualifying event.

Qualifying events include:

1. A *qualified individual* or *dependent* experiences a *loss* of *minimum essential coverage*, non-*calendar year* group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage.
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order.
    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.
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges.
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by us.
5. An enrollee or *dependent* adequately demonstrates to us that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee.
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to us that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or enrollee's decision to purchase the QHP.
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advanced premium tax credits* or has a change in *eligibility* for *cost-sharing reductions*.
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3).
9. A *qualified individual*, enrollee, or *dependent* gains access to new QHPs as a result of a permanent move and had *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 the permanent move.
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan, or change from one plan to another one time per month.
11. A *qualified individual* or enrollee demonstrates to us, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances

as the Health Insurance Marketplace may provide.

12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2 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 applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended.
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).
15. At the option of us, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan following termination of 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; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. Subject to the availability of enhanced tax subsidies, a *qualified individual* or enrollee, or their dependent who is eligible for advance payments of the premium tax credit, and whose household income is expected to be no greater than 150 percent of the Federal poverty level.

If you are currently enrolled in Ambetter from NH Healthy Families, please contact *Member* Services at 1 844-265-1278, TTY 1-855-742-0123 with any questions related to your health insurance coverage

Coverage Effective Dates for Special Enrollment Periods

Regular effective dates. Except as specified below, coverage will be effective on the first of the month following plan selection.

Special effective dates. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a *qualified individual* or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care. In the case of marriage, or in the case where a *qualified individual* experiences a *loss* of *minimum essential coverage*, coverage is effective on the first day of the following month.

In the case of erroneous enrollment, *contract* violation, or exceptional circumstances, coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by the Department of Health and Human Services. Such date must be either (i) the date of the event that triggered the special enrollment period or (ii) in accordance with the regular *effective dates*.

If a *qualified individual*, enrollee, or *dependent* loses coverage, gains access to a new QHP, becomes

newly eligible for enrollment in a QHP, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move, or is enrolled in COBRA continuation coverage and employer contributions to or government subsidies completely cease, and if the plan selection is made on or before the day of the triggering event we must ensure that the coverage *effective date* is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

If a *qualified individual*, enrollee, or *dependent* newly gains access to an ICHRA or is newly provided a QSEHRA, and if the plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following plan selection.

If a *qualified individual*, enrollee, or *dependent* did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a qualifying event occurred, we must allow the *qualified individual*, enrollee, or *dependent* to select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. And at the option of a *qualified individual*, enrollee or *dependent,* we must provide the earliest effective that would have been available, based on the applicable qualifying event.

Dependent Members
When you are enrolled and you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), you can log onto your consumer dashboard at enroll.ambetterhealth.com to process these changes.

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

1. The date of a member's death.
2. The primary *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan.
3. The date that a member is no longer within the Grace Period based on a failure to make timely payment. See the Grace Period provision for additional detail.
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
5. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request.

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact *Member* Services Department: 1-855-742-0123 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 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the 31st day of the grace period.
>
> We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect advanced premium tax credits on behalf of the *member* from the Department of the Treasury and will return the advanced premium tax credits on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

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

> Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 90-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

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

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
2. Indian tribes, tribal organizations or urban Indian organizations.
3. State and Federal Government programs.
4. Family members.
5. An employer for an employee under an ICHRA or 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.

Reinstatement
You may contact us for coverage reinstatement.

If your *contract* lapses due to nonpayment of premium, it may be reinstated provided:
1. We receive from you a written request for reinstatement within 60 days after the date coverage lapsed: and
2. The written request for reinstatement is accompanied by the required premium payment.

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

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

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

Change or Misstatement of Residence
If you change your *residence*, you must notify us of your new *residence* within 60 days of the change or log into your Ambetter *member* portal to process your change via Ambetter's *Enhanced Direct Enrollment tool*, of your new *residence* within sixty (60) days of the change. As a result, your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods provision for more information.

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

COST SHARING FEATURES

Cost sharing Features

We will pay benefits for *covered services* as described in the *Schedule of benefits* and the *covered services* sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that you participate or share in the cost of your 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 treat a condition or an *illness*. Each claim that we receive for services covered under this *contract* are adjudicated or processed as we receive them. Coverage is only provided for *eligible expenses*. Each claim received will be processed separately according to the cost share as outlined in the *contract* and in your *schedule of benefits*.

Deductible

The *deductible amount* means the amount of *covered services* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. The *deductible amoun*t does not include any *copayment amount* or *coinsurance* amount. Not all *covered services* 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* are due 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 service. *Copayments* do not count or apply toward the *deductible amount* but do apply toward your *maximum out-of-pocket amount*.

Coinsurance

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

Maximum out-of-pocket

You must pay any required *copayments* or *coinsurance amounts* required until you reach the *maximum out-of-pocket* amount shown on your *Schedule of Benefits*. After the *maximum out-of-pocket* amount is met for an individual, we will pay 100 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*.

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

1. Any specific benefit limits stated in the *contract*.
2. A determination of *eligible expenses.*
3. Any reduction for expenses incurred at a *non-network* provider. Please refer to the information on the *schedule of benefits*.

The applicable *deductible amount*(s), *cost sharing percentage*, and copayment amounts are shown on the *Schedule of benefits*.

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

When receiving care at an Ambetter *network* facility, it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with Ambetter 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 Ambetter.

As a *member* of Ambetter, *non-network* providers should not bill you for *covered services* for any amount greater than your applicable in-*network* cost sharing responsibilities when:

- 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.
- 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.
- 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 NH Health Families and underwritten by Celtic Insurance Company. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company, its designee and its affiliates, including Ambetter from WellCare of Kentucky, do not provide tax, investment or legal advice to members.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERING 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
In order to obtain benefits, you must designate a *network primary care physician* for each *member.* You may select any *network primary care physician* who is accepting new patients from any of the following provider types:

- Family practitioners
- General practitioners
- Internal medicine
- Nurse practitioners*
- *Physician* assistants
- Obstetricians/gynecologists
- Pediatricians (for children)

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

You may obtain a list of *networks primary care physicians* at our website and using the "Find a Provider" function or by contacting our Member Services.

You do not need a referral from your *network* primary care *physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network* specialist *physicians*, you may be required to obtain a referral from your *network* primary care *physician* for benefits to be payable under your policy or benefits payable under this policy may be reduced. Please refer to your Schedule of Benefits.

Changing Your primary ***Care Physician (PCP)***
You may change your *network primary care physician for any reason, but not more frequently than once a month,* by submitting a written request, online at our website at Ambetter.NHhealthyfamilies.com, or by contacting our office at the number shown on your *member* identification card. The change to your *network primary care physician* of record will be effective no later than 30 days from the date we receive your request.

Contacting Your *Primary Care Physician*
To make an appointment with your PCP, call his/her office during business hours and set up a date and time. If you need help, call *Member* Services at 1-877-617-0390 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 1-844-265-1278 (TTY 1-855-742-0123). 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. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A *network* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact *Member* Services prior to moving or as soon as possible. Note that *covered services* received from *non-network providers* are not *covered services* under this *contract* but you may have the opportunity to disenroll from coverage under this *contract* 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 *contract* for *non-network providers.*

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

Non-Emergency Services
If you are traveling outside of the New Hampshire *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 New Hampshire 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 obtain a referral from your primary care provider and/or 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 the nearest emergency room. Be sure to a call us and report your emergency within one business day. You do not need prior approval for emergency care services.

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

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 at 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*

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 Ambetter – 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 nonparticipating provider in excess of the *Eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket*.

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

MAJOR MEDICAL EXPENSE BENEFITS

The plan provides coverage for health care services for a *member* and/or dependents. Some services require preauthorization.

Copayment, *deductibles*, and *coinsurance* 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 *contract*. Covered service must be *medically necessary* and not *experimental or investigational.*

***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-a*cute rehabilitation* hospital, a skilled nursing facility or any other facility at which appropriate services or therapies may be provided. Service 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 plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an Acquired Brain Injury.
2. Has been unresponsive to treatment; and
3. Is medically stable, and
4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for 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

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration. *Custodial Care* is not a *covered service* under this *contract.*

Essential Health Benefits

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, *emergency* services, hospitalization, maternity and newborn care, mental health and *substance use disorder* services, including *behavioral health* treatment, *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care*. Essential Health Benefits* provided within this *contract* are not

subject to lifetime or annual dollar maximums. Certain non-*essential health benefits*, however, are subject to either a lifetime and/or annual dollar maximum.

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

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

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

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

Exclusions:
No benefits will be paid for:

1. Expenses incurred for air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Ambulance services provided for a *member's* comfort or convenience.
3. Non-*emergency* transportation excluding ambulances (for example- transport van, taxi). Note: non-emergency ambulance transportation requires *prior authorization*.

Air Ambulance Service Benefits
Covered services expenses will include ambulance services for ground, water, transportation by fixed wing and rotary wing air ambulance transportation from home, scene of accident, or medical emergency:

1. To the nearest *hospital* that can provide services appropriate to the member's *illness* or injury, in cases of *emergency*.
2. 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 NH Healthy Families.
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. Please 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 air ambulance transportation requires *prior authorization*.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency 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.
5. Non-*emergency* transportation excluding ambulances.

Autism Spectrum Disorder **Expense Benefit**
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.

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 work with you, your *Primary care physician (PCP)* and other providers to develop a care plan that meets your needs and your caregiver's needs.

If you think you could benefit from our *Care management* program, please call *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123).

Clinical Trial Coverage

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

1. The investigational item or service itself:
2. 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
3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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 who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Clinical trials can be approved if they are approved or funded by one of the following:

1. One of the National Institutes of Health (NIH).
2. The Centers for Disease Control and Prevention.
3. The Agency for Health Care Research and Quality.
4. The Centers for Medicare & Medicaid Services.
5. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs.
6. The FDA in the form of an investigational new drug application.

7. The study or investigation is a drug trial that is exempt from having such an investigational new drug application
8. The federal Departments of Veterans' Affairs, Defense, or Energy.
9. 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.
10. 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. A *qualified individual* must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate for the purposes of prevention, early detection, or treatment of cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would serve the purposes of prevention, early detection, or treatment of cancer or a life-threatening disease or condition.

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. Such documents shall be made available to us upon request.

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

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. Coverage is also provided for:

1. For *medically necessary* oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
    b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is *medically necessary* to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental injuries.
    d. Treatment for Temporomandibular Joint Disorder (TMJ), 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 participating hospital, surgical center, or office, provided to the following members:
    a. A *member* under the age of 19.
    b. a person who is severely disabled; or
    c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For 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.
4. For surgery, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

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

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

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

Covered expenses include:

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

After you receive appropriate training at a dialysis facility we designate, we cover equipment and

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

Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics
The supplies, equipment and appliances described below are *Covered services* under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum *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:

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

<u>*Durable medical equipment*</u>
The rental (or, at our option, the purchase) of *durable medical equipment* prescribed by a *Physician* or another Provider. *Durable medical equipment* is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of *illness* or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, *hospital* beds, and oxygen equipment. Rental costs must not be more than the purchase price. The plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *Covered services*. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting

supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

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

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

1. Air conditioners.
2. Ice bags/cold pack pump.
3. Raised toilet seats.
4. Rental of equipment if the *Member* is in a Facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.
8. Vehicle installations or modifications which may include but are not limited to adapted seat de-vices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

Medical and surgical supplies
Certain supplies and equipment for the management of disease that we approve are covered under the *Prescription drug* benefit.

Covered services may include, but are not limited to:

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

Exclusions:
Non-*Covered services* include but are not limited to:

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

petroleum jelly.

Prosthetics

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

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

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

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular 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.
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 (the first one following cancer treatment, not to exceed one per benefit period), when purchased through a *network* provider.

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)

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 device*s 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. d

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

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

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

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

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 & wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes, and applicators. The supplies are subject to the member's medical deductible, copay, and coinsurance.

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, seven days a week.

Please note some *providers* that treat you within the emergency room may not be contracted with Ambetter.

If that is the case, they may not *balance bill* you for the difference between our *allowed amount* and their billed amount.

Formulary or Prescription Drug List
The formulary or *prescription drug* list is a guide to available generic, 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.

Please 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 specific 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.NHhealthyfamilies.com (under "For *Member*", "Drug Coverage") or call *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123).

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

1. *Covered services* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be determined *medically necessary*;
3. *Covered services* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration.
4. *Covered services* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Coverage for a *Skilled Nursing Facility* is limited; please refer to the *Schedule of Benefits* for applicable limit information..
6. *Habilitation* and *Rehabilitation* Services are limited; please refer to the of Benefits for applicable limit information.
7. Coverage for Cardiac *Rehabilitation*, Physical Therapy, Pulmonary, Occupational Therapy, and Speech Therapy.

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; and
4. Care is primarily *custodial care*.

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

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

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

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

Home Health care 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* in *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. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care,* skilled services of a registered nurse or licensed practical nurse rendered on an *outpatient* basis.
3. Intravenous medication and pain medication.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental or purchase of *medically necessary durable medical equipment*. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.
7. Sleep studies 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.
8. Intermittent skilled nursing services by an R.N. or L.P.N.
9. Medical / social services.
10. Diagnostic services.
11. Nutritional guidance.
12. Training of the patient and/or family/caregiver.
13. Prenatal and postpartum homemaker visits.

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

Exclusion:
No benefits will be payable for charges related to *custodial care, including adult day care and related services* or educational care, under the Home Health care Expense Benefits.

Hospice Care Expense Benefits
Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice care program* or in home setting. *Covered services* include:

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

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

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

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

Hospital Benefits
Covered services are limited to charges made by a *hospital* for:

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

benefits for limitations.

7. A private *hospital* room when needed for isolation.

Infertility Services

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

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.

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.

Common conditions/services that may be considered *medically necessary* for LTACH level of care included, 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 others 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.

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 a specified location. Ambetter pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend members for participation in the lock-in program. Members identified for participation in the lock-in program and associated providers will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in and any *appeal*s rights.

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

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

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* including professional and facility services for childbirth in a Facility or the home, including the services of a New Hampshire Certified Midwife. 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 the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from s*urrogates*. Please reference General Non-*Covered services* and Exclusions as limitations may exist.

Post-Discharge Care
Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a *physician*. The location and schedule of the post-discharge visits shall be determined by the attending *physician*. Services provided by the registered professional nurse or *physician* shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending *physician* as medically appropriate.

Other maternity benefits include:

1. *Outpatient* and *inpatient* pre and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes. This does not require *prior authorization* as it is part of Maternity Care.
2. *Physician* Home Visits and Office Services. *Physician* Services and office visit do not require *prior authorization*.
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. This does not require *prior authorization* as it is part of Maternity Care.
4. Complications of pregnancy. This does not require *prior authorization* as it is part of Maternity Care.
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care. This does not require *prior authorization* as it is part of Maternity Care.

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

1. give birth in a *hospital* or other 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 the *contract* to restrict any terms, limits, or conditions that may otherwise apply to a *member* acting as a *surrogate* and children born from a *surrogate*. Please reference General Non-*Covered services* and Exclusions as limitations may exists.

You can reference the Evidence of Coverage *Prior Authorization* provision of this *contract* for additional details, call member services, go onto your member portal, or ask your physician, who in return could look up the CPT code for the service in the pre-screen tool on the NH website.

Duty to Cooperate

We do not cover services or supplies related to a *surrogate pregnancy* unless the *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-*Covered services* and Exclusions section. M*embers* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Ambetter NH Healthy Families at the *Member* Services, 2 Executive Park Drive, Bedford, NH 03110. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation, or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office, *inpatient* facility or at an *outpatient surgical facility,* including services and supplies.
2. For services received for urgent care,including facility charges at a *network provider urgent care center*.
3. For the professional services of a *medical practitioner,* including *surgery.*
4. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
5. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
6. For perfluoroalkyls (PFAS) and perfluorinated compound (PFC) blood testing.
7. For long-term antibiotic therapy for tick-borne *illness* when determined to be *medically necessary* and ordered by a licensed infectious disease *physician*.
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For accidental *dental expenses* when a *member* suffers an *injury,* that results in:
    a. Damage to his or her sound natural teeth and gums.
    b. Expenses are incurred or treatment is *authorized* as part of a treatment plan that was prescribed by a *physician*. *Injury* to the natural teeth will not include any *injury* as a result of chewing; and
    c. Treatment made necessary due to *injury* to the jaw and oral structures other than teeth are covered without time limit.
13. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer if the patient elect's reconstruction and in the manner chosen by the patient and the *physician*. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast, and *prosthetic devices* necessary, to restore a symmetrical appearance and

treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.

14. For *surgery*, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, as well as removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
15. For Chiropractic Care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary manipulative therapy* treatment on an *outpatient* basis and physiological therapy before (or in conjunction with) spinal adjustment. Please refer to the *Schedule of Benefits* for applicable limits;;
16. For pulse oximetry screening on a newborn.
17. For *medically necessary* transplants:
18. For *outpatient contraceptive services* for any type of drug or device for contraception, which is lawfully prescribed and has been approved by the FDA. Coverage for prescription contraceptives will be provided for a 12-month period, if prescribed in that quantity. Additionally, coverage is required for any *outpatient* services related to the use of a drug or device intended to prevent *pregnancy.* Benefits for prescription *outpatient contraceptive services* are exempt from any *deductible*s, *copayment,* and *coinsurance* provisions.
19. For dental procedure coverage for the medically necessary facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a *member* who:
    a. is a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed *primary care physician* to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or *hospital* setting; or
    b. is a person who has exceptional medical circumstances, or a developmental disability as determined by a licensed *primary care physician* which place the person at serious risk.
20. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is *medically necessary* and is the least restrictive and most cost-effective means for meeting the needs of the *member*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein.
21. 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*.
22. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's *primary care physician* if applicable.
23. For the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing *physician* has issued a written order stating that treatment is *medically necessary* and in accordance with the member's qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric *Surgery* or the American College of Surgeons. Such treatment standards may include, but not be limited to, pre-

operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post- operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. The covered insured person shall be at least 18 years of age.

24. For *medically necessary* diagnostic and laboratory and x-ray tests.
25. For telemedicine for *covered services* provided within the scope of practice of a *physician* or other health care provider as a method of delivery of medical care by which a *member* shall receive medical services from a health care provider without in-person contact with the provider.
26. For naturopathy providers.
27. For injections, including allergy injections.
28. For *Medically necessary* oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
    b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is *Medically necessary* to attain functional capacity of the affected part.
    c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
    d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are *Medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. *Reconstructive surgery*.
29. For *medically necessary* genetic blood tests.
30. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
31. *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.
32. 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
33. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any nonsymptomatic 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 nonsymptomatic 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 nonsymptomatic member, in accordance with the current American Cancer Society guidelines.

34. For accidental 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.
35. For surgery, excluding tooth extraction
36. For pulse oximetry screening on a newborn.
37. Well childcare examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Refer to Preventive Services for a list of well child/well baby services
38. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
39. Allergy testing, injections, and serum.
40. 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.
41. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage shall be subject to a written recommendation by the treating health care professional stating that the hair prosthesis is a *medical necessity*.
42. 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
43. 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 $150 per transplant
44. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following members:
    a. a *member* under the age of six
    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.
45. 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
46. For cancer screenings, as follows
    a. A pelvic examination and pap smear for any nonsymptomatic 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 nonsymptomatic 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 nonsymptomatic member, in accordance with the current American Cancer Society guidelines.
47. For respiratory and pulmonary therapy.
48. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV), and for *medically necessary* genetic blood tests.

49. 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.
50. Testing of pregnant women and other members for lead poisoning.
51. Medically necessary routine foot care, prior authorization may be required
52. Medically necessary nutritional counseling, prior authorization may be required

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.

Our *behavioral health* staff oversees the delivery of covered *behavioral health* and *substance use disorder* services for Ambetter from NH Healthy Families. Mental health services will be provided on an *inpatient* and *outpatient* basis and include mental health conditions. These conditions affect the individual's ability to cope with the requirements of daily living. If you need mental health and/or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health network*. You can search for *network Behavioral health* providers by using our Find a Provider tool at Ambetter.NHhealthyfamilies.com or by calling *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123). *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 contract.

When making coverage determinations, our *behavioral health* and *substance use disorder* staff utilizes established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Our *behavioral health* and *substance use disorder* staff utilizes 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.

At least one medication-assisted treatment therapy option that is approved by the federal Food and Drug Administration for treatment of *substance use disorders* is available without a requirement for *prior authorization*. In addition, we will not require a renewal of a *prior authorization* for a medication-assisted treatment therapy for treatment of *substance use disorders* more frequently than once every 12 months.

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 disorder*; 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 disorder*.
6. Individual and group therapy for mental health and *substance use disorder*.
7. Medication Assisted Treatment, combines behavioral therapy and medications to treat *substance use disorder*;
8. Medication management services.
9. Psychological and Neuropsychological testing and assessment.
10. Applied Behavioral Analysis for treatment of autism.
11. Telehealth.
12. Electroconvulsive Therapy (ECT); and
13. Transcranial Magnetic Stimulation (TMS)
14. Assertive Community Treatment (ACT)

Behavioral health covered services are only for the diagnosis and treatment of *substance use disorder*/chemical dependency and mental health conditions. This includes Obsessive Compulsive disorder, including pediatric autoimmune neuropsychiatric disorders.

In addition, Integrated *Care management* is available for all of your health care needs, including *behavioral health* and *substance use disorder*. Please call 1-844-265-1278 (TTY 1-855-742-0123) to be referred to a care manager for an assessment.

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

Newborn Charges

Medically necessary services, including *hospital* services, are provided for a covered newborn child immediately after birth. Please refer to the *Dependent member* Coverage section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

Newborns and Mothers' Health Protection Act Statement of Rights

If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered services*, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean

section. However, we may provide benefits for *covered services* incurred for a shorter stay if the attending provider (e.g., your *physician*, nurse, certified midwife, or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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 y*our medical practitioner*. Your *medical practitioner* can utilize the usual *prior authorization* request process. See "*Prescription drug* Exception Process" for additional details.

Outpatient Medical Supplies Expense Benefits
Covered services for *outpatient* medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *member* and the item cannot be modified. If more than one prosthetic
2. device can meet a *member's* functional needs, only the charge for the most cost-effective *prosthetic device* will be considered a *covered service expense*.
3. For one pair of foot orthotics per year per *member*
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 cost of one Continuous Passive Motion (CPM) machine per *member* following a joint surgery.
6. Infusion therapy.
7. For one pair of eyeglasses or contact lenses per *member* following a cataract surgery, or if the lens of your eye has been surgically removed or is congenitally absent.

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* (including epinephrine auto injectors*).*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and

effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical j*our*nal published in the United States or Great Britain; and

4. Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal *transplant*.
5. Prescribed, oral anticancer medication.

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

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.

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

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

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

A *member*, a *member's 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 enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non- formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

Exception for drugs available on the formulary during previous 12 months:
For any non-formulary drug that was available as formulary product during previous 12 months, you have the right to request a formulary exception. To request a formulary exception please call our vendor Envolve Pharmacy Solutions at 1-866-399-0928. You or your provider can also request a formulary exception

through faxing the request to 1-866-399-0929.

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

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

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

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

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.

Prescription refills are subject to the following:

<u>Ophthalmic prescriptions</u>
Refills for ophthalmic prescription medications based on days' supply of the original fill or the most recent fill of the prescription.

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

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

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

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

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

For example, if *member* fills a 90-day supply of an ophthalmic medication the *member* will be able to refill

that ophthalmic medication on the 63rd day after the original or most recent fill of the medication.

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

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

Cost sharing paid on your behalf for any *prescription drugs* obtained by you through the use of a drug discount, coupon, or copay card provided by a *prescription drug* manufacturer will not apply toward your plan deductible or your *maximum out-of-pocket*.

Cost sharing paid on your behalf for any *prescription drugs* with a generic equivalent will not apply toward your plan deductible or your maximum out of pocket if a *drug discount, coupon, copayment card*, or manufacturer supplied prepaid credit card was used.

Non-*Covered services* and Exclusions:
No benefits will be paid under this benefit provision for expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member*, in whole or part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution, that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over the counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or *experimental* drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that 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.

12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an *Emergency* Medical Condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. Medication used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. 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 drug dispensed from a non-lock-in pharmacy while *member* is in lock-in program (see Lock-in Program provision below).
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 opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims (see Lock-in Program provision below; or
22. For prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
23. 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; and
24. Medication refills where a *member* has more than 15 days' supply of medication on hand.
25. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.
26. For immunization agents otherwise not required by the Affordable Care Act

Self-injectable Drugs

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

How to Fill a Prescription

Prescription orders can be filled at a *network* retail pharmacy or through our mail order pharmacy. If you decide to have your prescription 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.NHhealthyfamilies.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.NHhealthyfamilies.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 1-888-239-7690. Alternatively, you can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on our Ambetter website. Once on our website, click on the section, "For Member," "Drug Coverage." The enrollment form will be located under "Forms."

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.

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.

Prostate Specific Antigen Testing
Covered expenses 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 covered person who is at least fifty (50) years of age; and at least once annually for a covered person who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

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

1. Routine ophthalmological examination
    a. Refraction.
    b. Dilation;
2. Contact lens fitting, 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 optical aids as *medically necessary*.

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

Services not covered:

1. Visual therapy.
2. Two pair of glasses as a substitute for bifocals.
3. *Non-network* care without *prior authorization*.
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 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 may require a referral through your primary care *physician*.

Vision Services under the medical portion of your health plan do not include:

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

If you have elected additional Adult Vision Benefits, please refer to the Adult Vision Benefits sections of this *contract.*

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:

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).

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

Preventive care benefits obtained from a *network* provider are covered without *member* cost share (i.e., covered in full without deductible, coinsurance, or copayment). 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.

Notification
As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *contract.* You may access our website or the *Member* Services Department at 1-855-650-3789 to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at ambetter.homestatehealth.com.

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).

Respite Care **Expense Benefits**

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

Second Medical Opinion

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

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

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network provider* listed in the 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 the additional *cost sharing*.

Social Determinants of Health **Supplemental Benefits**

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

Social determinants of health benefits and services may be offered to *members* through the "My Health Pays" wellness program and through 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.NHhealthyfamilies.com or by contacting *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123).

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

Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *contract. Prior authorization* must be obtained through the "*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 *contract* will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollee'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 *contract* will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

If we determine that a *member* is an appropriate candidate for a *medically necessary transplant,* Medical Benefits *covered services* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including *outpatient covered services* related to the transplant surgery, pre- transplant laboratory testing and treatment, such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of excellence* and services are performed at participating facility.
7. Post- transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations at Ambetter.nhhealthyfamilies.com

These medical expenses are covered to the extent that the benefits remain and are available under the enrollee's *contract,* after benefits for the enrollee's own expenses have been paid. In the event of such

coverage, the otherwise existing coverage of a live donor shall be secondary to benefits under the enrollee's *contract.*

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

1. They would otherwise be considered *covered services* under the *contract.*
2. The *member* received an organ or bone marrow of the live donor; and
3. The *transplant* was a *medically necessary*.

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

1. *Covered services* for the *transplant* will include the acquisition cost of the organ or bone marrow; and
2. We will pay a maximum of $10,000 per lifetime for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence.* We will pay the costs directly for transportation and lodging, however, you must make the arrangements.

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

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

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

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

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

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

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

Excluded are any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods or meals, baby formula or food and formula for access problems.

Chiropractic Services
We cover charges for *chiropractic services*. These services will be covered for a *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor.

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.

Family Planning and Contraception
Family planning/contraception benefits are covered under preventive care, without cost sharing (when provided by a contracted provider). These benefits include the following for adolescent and adult women, in accordance with the most recent guidelines supported by 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 necessary.
- 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.

PRIOR AUTHORIZATION

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

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

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

For services or supplies that require *prior authorization,* you must obtain *authorization* from us before you or your *dependent member:*

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

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

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

Prior Authorization (medical and behavioral health) requests shall be received by telephone, efax, or provider web portal as follows:

1. At least five days prior to an elective admission as an *inpatient* in a hospital, extended care, or *rehabilitation facility*,

2. *hospice* facility, or residential treatment facility.
3. At least 30 days prior to the initial evaluation for organ *transplant* services.
4. At least 30 days prior to receiving clinical trial services.
5. Within 48 hours of any *inpatient* admission, including emergent *inpatient* admissions, or as reasonably practicable.
6. At least five days prior to the start of home health care except for *members* needing *home health care* after *hospital* discharge.

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

1. For urgent concurrent review within 24 hours of receipt of the request.
2. For urgent pre-service *reviews*, within 72 hours from date of receipt of request.
3. For non-urgent pre-service *reviews* within five days but no longer than 15 days of receipt of the request.
4. For post-service or *retrospective reviews*, within 30 calendar days of receipt of the request.

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

How to Obtain *Prior Authorization*

To obtain prior *authorization* or to confirm that a *network provider* has obtained prior *authorization*, contact us by telephone at the telephone number listed on your *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. A reduction in benefits will be not more than 50 percent of the benefit that would have otherwise been payable or $1,000.00, whichever is less. Services rendered that fail to comply with *prior authorization* are subject to *medical necessity* review.

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

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

***Prior Authorization* Does Not Guarantee Benefits**

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

Requests for Predeterminations

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

1. The predetermination was based on incomplete or inaccurate information initially received by us.

2. Another party has already paid or is responsible for payment of the medical expense.

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

Services from *Non-network Providers*

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

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to you or your covered *dependent* in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on you or your covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of the *member's immediate family; and*
4. Any services not identified and included as *covered services* under the *contract*.You will be fully responsible for payment for any services that are not *covered services.*
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 *contract,* no benefit will be paid for a service or supply unless it is:

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

Covered 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 *contract*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and weight loss programs, except as specifically covered in this *contract*.
4. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of gender dysphoria.
5. For the reversal of sterilization and the reversal of vasectomies.
6. For abortion unless *medically necessary* or the life of the mother would be endangered if the fetus were carried to term.
7. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For failure to keep a scheduled appointment.
11. For telephone consultations between providers, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment.
12. For stand-by availability of a *medical practitioner* when no treatment is rendered.
13. For *dental expenses,* including braces for any medical or dental condition, *surgery,* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits.
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* resulting from trauma, infection, or other diseases of the involved part, and

reconstructive surgery because of congenital disease or anomaly of a covered *dependent* child that has resulted in a functional defect.

15. Mental health services are excluded:
    a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work unless a plan *physician* determines such evaluation to be *medically necessary*.
    b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a plan *physician* determines such Services to be *medically necessary*.
    c. Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
    d. Services which are custodial in nature.
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the *Transplant* Expense Benefits.
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 by the *contract*.
19. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *contract*.
21. For *experimental or investigational* or *unproven services.* The fact that an *experimental or investigational* 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* or *unproven service* for the treatment of that particular condition.
22. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency**.** Coverage is provided under the *contract* when a *member* waives worker's compensation coverage in accordance with New Hampshire law.
23. For fetal reduction surgery.
24. Except as specifically identified as a *covered service expense* under the *contract*, or as directed by a *Naturopathic physician,* expenses for 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.
25. Care or complications resulting from non-*covered services,* except for services we would otherwise cover to treat complications from the non-covered service.
26. For the following miscellaneous items, unless specifically described in this *contract*: artificial insemination except where required by federal or state law; biofeedback; chelating agents; domiciliary care; food and food supplements; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; *rehabilitation* services for

the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses;

27. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
28. Services or supplies eligible for payment under either Federal or State Programs (except Medicaid). This exclusion applies whether or not you assert your right to obtain this coverage or payment of the services.
29. For any medicinal and recreational use of cannabis or marijuana; and
30. *Surrogacy Arrangement.* Health care services, including supplies and medication, to a *surrogate*, who is not a *member* under this *contract.* This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care.
    b. Intrapartum care (or care provided during delivery and childbirth).
    c. Postpartum care (or care for the *surrogate* following childbirth).
    d. Mental health services related to the *surrogacy arrangement*.
    e. Expenses relating to donor semen, including collection and preparation for implantation.
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*.
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*.
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*.
    i. Any complications of the child or *surrogate* resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insured's possessing an active *contract* with us and/or the child possesses an active *contract* with us at the time of birth.

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request.
3. The date we decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of your death, if you are the only *member* on this *contract*.
5. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* reaches the limiting age of 26.
6. The date your eligibility for coverage under this *contract* ceases as determined by us.

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

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

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

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

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 the primary *member* for support.

Refund Upon Cancellation
We will refund any premium paid and not earned due to *contract* termination. You may cancel the *contract* at any time by providing written notice, to the entity with 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.

Discontinuance
90-Day Notice:
If we discontinue offering all policies issued on this form at the end of the plan year, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage. You will be offered an

option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status**.**

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

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

REIMBURSEMENT

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

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

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

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

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

Reimbursement for Emergency Room Boarding
We will pay the acute care *hospital* a per diem day rate required to board and care for the *member*, for each day the *member* is waiting in an acute care medical *hospital* located in the State of New Hampshire. The day rate required to board and care for the *member* may be billed for up to 21 days or discharge, whichever is sooner, and shall be renewed as needed for patient protection. The rate is deemed to cover all costs incurred by a *hospital* for the boarding and non-medical care of the *member* and shall not be billed to the *member*. This does not preclude a *hospital* from billing for other *medically necessary* services.

CLAIMS

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

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

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

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

How to Submit a Claim
Providers will typically submit claims on your behalf, but sometimes you may need to submit claims y*our*self 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 an explanation of why you paid for the *covered services* along with the *member* reimbursement claim form posted at Ambetter.NHhealthyfamilies.com under "For *Members* – Forms and Materials". Send all the documentation to us at the following address:

Ambetter from NH Healthy Families
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 *contract* and as often as may be reasonably necessary:

1. Sign, date and deliver to us *authorization*s to obtain any medical or other information, records or documents we deem relevant from any person or entity.

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

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

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

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

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

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

Any claim not paid within the time periods specified shall be deemed overdue. When a claim is overdue, the health care provider may notify Ambetter from NH Healthy Families in writing of

Ambetter from NH Healthy Families noncompliance. If we fail to pay the claim within the allotted time, then:

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

Foreign Claims Incurred for *Emergency* Care

Medical emergency care is a *covered service* while traveling for up to a maximum of 180 consecutive days. If travel extends beyond 180 consecutive days, no benefit coverage is provided for medical emergencies for the entire period of travel including the first 180 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. Foreign claims must also include the applicable medical records in English to show proper *proof of loss* and evidence of payment to 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.NHhealthyfamilies.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 the health plan has 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, *member* will be issued reimbursement payment for any eligible incurred costs, minus *member* cost share obligation.

Medicaid Reimbursement

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

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

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

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

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

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

Upon request by the custodial parent, we will:

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

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

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

Non-Assignment
The coverage, rights, privileges, and benefits provided for under this *contract* are not assignable by you or anyone acting on your behalf. Any assignment or purported assignment of coverage, rights, privileges, and benefits provided for under this *contract* that you may provide or execute in favor of any *hospital*, provider, or any other person or entity shall be null and void and shall not impose any obligation on us.

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

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

INTERNAL GRIEVANCE, INTERNAL *APPEALS* AND EXTERNAL REVIEW PROCEDURES

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 our *Member* Services team at 1-844-265-1278, (TTY 1-855-742-0123) 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.

Internal Grievance

Internal Grievance Procedures:

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

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

You or your *authorized representative* may file the *grievance* in writing, either by mail or by facsimile (fax). If you require assistance in filing a *grievance* or if you are unable to submit the *grievance* in writing, you can call Member Services 1-844-265-1278 (TTY 1-855-742-0123) to ask for help through the process.

Ambetter from NH Healthy Families
Grievances & Appeals Department
2 Executive Park Drive Bedford, NH 03310
Fax: 1-877-851-3992

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

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

We will give you an answer in writing as expeditiously as your health requires, not to exceed

72 hours from receipt of your clinically urgent *grievance* or within thirty (30) calendar days from receipt of your non-urgent grievance.

The plan may extend the timeframe for disposition of a *grievance* for up to 14 calendar days if the *member* requests the extension or the plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the *member's* interest. If the plan extends the timeframe, it shall, for any extension not requested by the *member*, give the *member* written notice of the reason for the delay. plan will notify *member* of the *grievance* resolution in writing within two (2) business days of the resolution not to exceed the total resolution timeframe (i.e., 30 calendar days). The notice of resolution shall include the results of the resolution process, detail to identify the *grievance* (provider, claim number, diagnosis, etc.), the date it was completed and further *appeal* rights, if any.

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

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

Internal *Appeals*

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

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

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

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

- The plan will acknowledge all oral or written *appeals* in writing within five business days of the receipt of a request for an *appeal*.
- If you do not speak English, you may be entitled to receive *appeal*s' information in your native language upon request.
- When you request an internal *appeal*, the plan must give you its decision as soon as possible, but no later than:
    - 72 hours after receiving your request when you are appealing the denial of an

authorization for urgent care. (If your *appeal* concerns urgent care, you may be able to have the internal expedited *appeal* and external reviews take place at the same time.)

- 30 days for *appeal*s of denials of non-urgent care you have not yet received (pre-service denials).
- 30 days for *appeal*s of denials of services you have already received (post-service denials).
- The plan may extend the resolution notification time frame, for standard *appeal*s, to 45 calendar days to obtain additional information only if:
    1. The information was not submitted with the original request and
    2. The plan requested the information within 24 hours for expedited *appeal*s and within 15 business days for standard *appeal*s.

Your rights to file an appeal of denial of health benefits: You or your *authorized representative*, such as your health care provider, may file the *appeal* for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an *appeal* by telephone 1-844-265-1278, (TTY 1-855-742-0123)

Ambetter from NH Healthy Families
Grievances & Appeals Department
2 Executive Park Drive Bedford, NH 03310
Fax: 1-877-851-3992

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

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

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

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

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

review and external review").

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

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

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

Non-urgent, pre-service appeal

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

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

The plan will provide notification of the determination within 30 days of receiving your request for *appeal* unless the timeframe was extended because additional information was required. In such a scenario, the plan will provide notification of the determination within 45 days of the date we notified you of what information is required.

Urgent Pre-service (Expedited) Appeal

If your **appeal is urgent,** you **or** your ***authorized representative*, or** your **health care provider (*physician*) may contact us with the claim, orally or in writing.**

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

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

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

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

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

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

Simultaneous expedited internal appeal and expedited external review:

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

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

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

(1) You have filed a request for an expedited internal review; and
(2) After a final *adverse benefit determination* if either of the following applies:
    (a) Your treating *physician* certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of you or would

jeopardize your ability to regain maximum function, if treated after the time frame of a standard external review.
(b) The final *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care service for which you received *emergency* services, but you have not yet been discharged from a facility.

Concurrent care decisions

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

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

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

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

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

Post-service appeal of a claim denial (retrospective)

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

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

External Review

An external review decision is binding on us. An external review decision is binding on the *claimant* except to the extent the *claimant* has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility

The External Review procedures apply to:

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

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

1. The internal *appeal* process must be exhausted before the *claimant* may request an external review unless the *claimant* files a request for an expedited external review at the same time as an internal *expedited grievance* or we either provide a waiver of this requirement or fail to follow the *appeal* process.
2. A health plan must allow a *claimant* to make a request for an expedited external review with the plan at the time the *claimant* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *claimant* for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an internal *expedited grievance*; and
    b. A final internal *adverse benefit determination*, if the *claimant* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or 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.

External review is available for *appeals* 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.

Standard External Review Process

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

Expedited External Review Process

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

Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*. The eligible grievant/*claimant* may file a request for an external review with the New Hampshire Insurance Department at 21 South Fruit Street, Suite 14, Concord, NH 03301 or at 603-271-2261.

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

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

***Appeals* and Grievances filing, External Review, and key communication timelines**

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	5 Business Days	30 Calendar Days	14 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	15 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	15 Calendar Days
External Review	180 Calendar Days	N/A	60 Calendar Days	N/A
Expedited External Review	180 Calendar Days	N/A	72 Hours	N/A

You can also view your *appeal* and *grievance* information in your *member* secure portal.

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

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

The order of benefit determination rules determine whether this *contract* is a "primary plan" or "secondary plan" when you have health care coverage under more than one plan. When this *contract* is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this *contract* is secondary, it determines its

benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. If this *contract* is secondary, it will not be required to pay an amount in excess of its maximum benefit.

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

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

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

1. The difference between the cost of a semi-private *Hospital* room and a private *Hospital* room is not an Allowable Expense, unless one of the Plans provides coverage for private *Hospital* room expenses.
2. If you are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. The amount of any benefit reduction by the primary plan because a *member* has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

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

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

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

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

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

1. For a child whose parents are married or are living together, whether or not they have ever been married:
    a. The plan of the parent whose birthday falls earlier in the *calendar year* is the primary plan; or
    b. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
2. For a child whose parents are divorced or separated or not living together, whether or

not they have ever been married:

a. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, then that parent's spouse's plan is the primary plan. This rule applies to claim determination periods commencing after the plan is given notice of the court decree.
b. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits.
c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    i. The plan covering the Custodial Parent, first.
    ii. The plan covering the Spouse of the Custodial Parent, second.
    iii. The plan covering the non-custodial parent, third; and then
    iv. The plan covering the Spouse of the non-custodial parent, last.

3. For a child covered under more than one plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child (ren) whose parents are married or are living together or for child (ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee

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

COBRA or State Continuation Coverage

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

Longer or Shorter Length of Coverage

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

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

Effect on the Benefits of This plan

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other

issuers or plans. If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your *network provider* should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the *other plan* to determine which is primary and will let you know within 30 calendar days.

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

Personal Health Information (PHI)
Your health information is personal. We are committed to do everything we can 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 how 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.nhhealthyfamilies.com /privacy-practices.html or call *Member* Services at 1-844-265-1278 (TTY 1-855-742-0123). We protect all of your PHI. We follow HIPAA to keep your health care information private.

Language
If you don't speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: ambetter.nhhealthyfamilies.com /language-assistance.html.

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

PATIENT'S BILL OF RIGHTS

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

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

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

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

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

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

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the

patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

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

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

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

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

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

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

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

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

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, gender identity, age, disability, marital status, or source of payment, nor shall

any such care be denied on account of the patient's sexual orientation.

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

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

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

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

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de NH Healthy Families, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-265-1278 (TTY/TDD 1-855-742-0123).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from NH Healthy Families, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from NH Healthy Families 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-844-265-1278 (TTY/TDD 1-855-742-0123)。
Nepali:	यदि तपाईं वा तपाईंले मद्दत गरिरहनुभएको कोही व्यक्तिसँग Ambetter from NH Healthy Families सम्बन्धी कुनै प्रश्नहरू भएको खण्डमा तपाईंहरूसँग आफ्नै भाषामा निःशुल्क मद्दत र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्नका लागि 1-844-265-1278 (TTY/TDD 1-855-742-0123) नम्बरमा कल गर्नुहोस्।
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from NH Healthy Families, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from NH Healthy Families, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from NH Healthy Families, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from NH Healthy Families، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from NH Healthy Families, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Indonesian:	Jika Anda, atau orang yang Anda bantu, memiliki pertanyaan tentang Ambetter from NH Healthy Families, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan juru bicara, hubungi 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from NH Healthy Families 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-265-1278 (TTY/TDD 1-855-742-0123) 로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from NH Healthy Families вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-265-1278 (TTY/TDD 1-855-742-0123).
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from NH Healthy Families, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Bantu:	Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from NH Healthy Families, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from NH Healthy Families, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-844-265-1278 (TTY/TDD 1-855-742-0123).

Statement of Non-Discrimination

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

Ambetter from NH Healthy Families:

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

If you need these services, contact Ambetter from NH Healthy Families at 1-844-265-1278 (TTY~~/TDD~~ 1-855-742-0123).

If you believe that Ambetter from NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with: Ambetter from NH Healthy Families *Appeals* Department, 2 Executive Park Drive, Bedford, NH 03110, 1-844-265-1278 (TTY~~/TDD~~ 1-855-742-0123), Fax 1-877-851-3992. You can file a *grievance* in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from NH Healthy Families is available to help you. You can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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