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2024 Evidence of Coverage

Ambetter.WesternSkyCommunityCare.com

IMPORTANT NOTICE

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

Ambetter from Western Sky Community Care, Inc.

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

Major Medical Expense Insurance Policy

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

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

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

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

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

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

Western Sky Community Care, Inc.

Jean D. Wilms
CEO and Plan President

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INTRODUCTION

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

It describes:

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

This *policy*, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this *policy* shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this *policy* or to waive any of its provisions.

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

How to Contact Us

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

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

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

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

Interpreter Services

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

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

To arrange for interpreter services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

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

You have the right to:

1. Participate with your *physician* and *medical practitioners* in making decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized representative. You will be informed of your care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Have services available and accessible when *medically necessary*.
5. Have access to urgent and *emergency services* 24 hours per *day*, seven *days* per week, and for other health care services as defined by the *policy*.
6. Be treated with courtesy and consideration, and with respect for the *covered person*'s dignity and need for privacy.
7. Be provided with information concerning our policies and procedures regarding products, services, *providers*, and *appeals* procedures and other information about the company and the benefits provided.
8. Privacy of your personal health information, consistent with state and federal laws, and

our policies.

9. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians, medical practitioners*, *hospitals* and other facilities and your rights and responsibilities.
10. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the *policy*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally authorized representative. Your *physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
11. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
12. See your *medical records*.
13. Be kept informed of *covered* and non-covered services, program changes, how to access services, *PCP* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar *days* before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
14. Receive prompt notification in writing of termination or changes in benefits, services or *provider network*.
15. A current list of *participating providers*.
16. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
17. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability or expected health or genetic status.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
19. Access and correct any and all *confidential abuse information* that we may have concerning you in compliance with the New Mexico Domestic Abuse Act. http://ambetter.westernskycommunitycare.com/resources/handbook-forms.html
20. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your *provider*(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *physician's* instructions are not followed. You should discuss all concerns about treatment with your *physician*. Your *physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
21. A complete explanation of why care is denied.

22. An opportunity to *appeal* the denial decision to us, the right to a secondary *appeal*, and the right to request the superintendent's assistance.
23. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *participating providers* close to your home or work.
24. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
25. An interpreter when you do not speak or understand the language of the area.
26. A *second opinion* by a *network physician* if you want more information about your treatment.
27. Make advance directives for health care decisions. This includes planning treatment before you need it.
28. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing Advanced directive forms. Advance directives forms are forms you can complete to protect your rights for medical care. It can help your *PCP* and other *providers* understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.
29. Receive premium and claim data within 60 calendar *days* of receipt of a written request. We will provide premium data and redirect you to beWellnm (Exchange) for any detailed premium data to include the sum of all premiums charged or billed for the insurance policy. The claims data will include the sum of all amounts paid out pursuant to claims covered under the policy; a list of all pending claims against the policy which are open; and cumulative loss or claim reserves chargeable to the policy.

You have the responsibility to:

1. Read this *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician*, and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your

physician. You may change your *PCP* verbally or in writing by contacting Member Services.

7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
13. Pay your monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *coinsurance amounts* on time.
14. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *policy* within 60 calendar *days* of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where *member cost share* would need to transfer from one policy to another policy.

IMPORTANT INFORMATION

Provider Directory

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

You may also contact us by calling Member Services or by visiting Ambetter.WesternSkyCommunityCare.com to request information about whether a *physician*, *hospital*, or other *medical practitioner* is a *network provider*. We will respond to any such requests within one business *day*.

If you receive services from a *non-participating provider* because of inaccurate information in the provider directory or in response to an inquiry about *network* status, please contact us. If the services you received are otherwise *covered services*, you will only be responsible for paying the cost-sharing that applies to *network providers* and will not be *balance billed* by the *non-network provider*.

At any time, you can request a copy of the Provider Directory at no charge by calling Member Services. You may also report any provider directory inaccuracies to Member Services. We will not hold a *member* responsible for non-network care where the covered person relied upon inaccurate Provider Directory information to seek care. In order to obtain benefits, you must designate a *network primary care practitioner (PCP)* for each *member.* We can also help you pick a *PCP*. We can make your choice of *PCP* effective on the next *business day*.

Call the *PCP's* office if you want to make an appointment. If you need help, call Member Services. We will help you make the appointment.

Member Identification Card

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

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. Any applicable deductibles, and any

applicable out-of-pocket maximum limitations will also be accessible through the member identification card. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services. We will send you another card. A temporary identification card can be downloaded from Ambetter.WesternSkyCommunityCare.com.

Website

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

1. Finding a *network provider*, including *hospitals* and pharmacies.
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments, and obtain a copy of your *member* identification card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our Formulary or Prescription Drug List.
8. *Deductible amount* and *copayment amount* accumulators.
9. Selecting a *primary care practitioner*.

Quality Improvement

We are committed to providing quality health care for you and your family. Our primary goal is to improve your health and help you with any *illness* or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards and National Academy of Medicine (NAM) priorities. To help promote safe, reliable, and quality health care, our programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Providing programs and educational items about general health care and specific diseases.
3. Sending reminders to *members* to get annual tests such as a physical examination, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee which includes *participating providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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

Protection from Balance Billing
Under Federal law, effective January 1, 2022, *non-participating providers* or facilities are prohibited from *balance billing* health plan *members* for services that are subject to *balance billing protections* as described in the Definitions section of this *policy*. You will only be responsible for paying your *member cost share* for these services, which is calculated as if you had received the services from a *participating provider* and based on the recognized amount as defined in *applicable law*.

DEFINITIONS

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

Wherever used in this *policy*:

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

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

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

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

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

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

Adverse determination means a decision made either pre-service or post-service, by a health care insurer that a health care service requested by a *provider* or *covered person* has been reviewed and, based upon the information available, does not meet the health care insurer's requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated. An *adverse determination* may also occur where there is a determination that *balance billing protections* do not apply to a service, or an incorrectly-calculated amount of *cost sharing* a *member* owes when *balance billing protections* apply occurs

Allowed amount (also see ***Eligible expense***) means the maximum portion of a billed charge that a health insurance carrier will pay, including any applicable *covered person cost sharing*

responsibility, for a covered health care service or item rendered by a *participating provider* or by a *non-participating provider*.

Note: If you receive services from a *non-participating provider*, you may be responsible for the difference between the amount the *provider* charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your *policy*. See *Balance Billing, Balance Billing Protections,* and *Non-Participating Provider* definitions for additional information. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

Ambetter-designated Telehealth Provider means the vendor selected by Ambetter to contract with providers to render telehealth services, including *Virtual 24/7 Care* benefits, to members. All services provided through the *Ambetter-designated telehealth provider* shall be deemed independent from Ambetter to ensure that a member's care and treatment plan are rendered via a practicing physician, or other medical professional with appropriate licensure.

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

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

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

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

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

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

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

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

Balance billing protections means the protections against *balance billing* under the federal No Surprises Act. These protections apply to *covered services* that are:

1. *Emergency services* provided to a *member*, as well as services provided after the *member* is *stabilized* unless the *member* gave *notice and consent* to be *balance billed* for the post-*stabilization* services;
2. Non-emergency health care services provided to a *member* at a *facility* unless if *member* gave *notice and consent* pursuant to the federal No Surprises Act to be *balance billed* by the *non-participating provider*; or
3. *Air ambulance services* provided to a *member* by a *non-participating provider*.

You will only be responsible for paying your *member cost share* for these services, which is calculated as if you had received the services from a *participating provider* and is based on the recognized amount as defined in *applicable law.* If you are *balance billed* for any of the above services, contact Member Services immediately at the number listed on the back of your *member* identification card.

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

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

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

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. *Biomarker* includes gene mutations, characteristics of genes or protein expression.

Biomarker testing means analysis of a patient's tissue, blood or other biospecimen for the presence of a *biomarker* and includes single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing.

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

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

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

Complications of pregnancy means:

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

Confidential abuse information means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the

status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship.

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 or was determined to be *terminally ill* and is receiving treatment for such *illness*.

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

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

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

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

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

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

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

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

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

Day or ***days*** shall be interpreted as follows, unless otherwise specified:
1. One to five *days* means only working *days* and excludes weekend and state holidays; and
2. Six or more *days* means calendar *days*, including weekends and state holidays.

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

If you are a covered *member* in a family of two or more *members*, you will satisfy your *deductible amount* when:
1. You satisfy your individual *deductible amount*; or
2. Your family satisfies the family *deductible amount* for the *calendar year*.

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

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

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

Diagnostic breast examination means a *medically necessary* and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality: (a) seen or suspected from a screening examination for breast cancer; or (b) detected by another means of examination.

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

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

Eligible child means the child of a primary *subscriber*, if that child is less than 26 years of age. If an *eligible child* turns 26 during the plan year, they remain an *eligible child* through the end of the plan year.
As used in this definition, "child" means:

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

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

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

1. For *participating providers*: When a *covered service* is received from a *participating provider*, the *eligible expense* is the contracted fee with that *provider*.
2. For *non-participating providers*, unless otherwise required by New Mexico law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* received from a *non-participating provider* within New Mexico, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. 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*.

For all other *covered services* received from a *non-participating provider* for which any needed *authorization* is received from us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you should not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*. In addition to applicable *cost sharing*, you may be *balanced billed* for these services.

Emergency condition means a medical condition, *behavioral health* condition, or substance use disorder manifesting itself by symptoms of sufficient severity (including severe pain) that a reasonable layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following, regardless of eventual diagnosis:

1. Placing the health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part; or
4. Disfigurement to a person.

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

Emergency services means *covered services* needed to evaluate and stabilize an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department or *independent freestanding emergency department* to evaluate the emergency condition, as well as services needed to *stabilize* the *emergency condition*. Services to *stabilize* an *emergency condition* can be provided in any department of a *hospital*.

***Follow-up care is not considered* emergency care.** Benefits are provided for the treatment of *emergency services* without *prior authorization*. Benefits for *emergency services* include *facility* costs and *physician* services, and supplies and *prescription drugs* charged by that *facility*. If you are admitted into the *hospital* as a result of an *emergency condition,* you must give notification of your admission within 48 hours or as soon as possible within a reasonable period of time. A coma is an example of physically being unable to notify us of admission within 48 hours. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of *days* considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *policy*. If your provider does not contract with us, you may be financially responsible for any care we determine is not a *covered service* because it is not *medically necessary*. Care and treatment provided once you are *stabilized* is no longer considered *emergency services* under your *policy.* Continuation of care beyond what needed to evaluate or *stabilize* your condition in an *emergency* will be a covered *service* unless we *authorize* the continuation of care and it is *medically necessary*.

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

Experimental or investigational means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or

medications that, after consultation with a medical professional, we determine to be any of the following:

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

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

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

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

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

Facility means an entity providing health care service, including:

1. A general, specialized, psychiatric or *rehabilitation hospital*;
2. An *ambulatory surgical center*;
3. A cancer treatment center;
4. A birth center;
5. An impatient, outpatient or residential drug and alcohol treatment center;
6. A laboratory, diagnostic or other outpatient medical evaluation or testing center;
7. A health care *provider's* office or clinic;
8. An *urgent care center*; or
9. Any other therapeutic health care setting.

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

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

Generally recognized standards means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including psychiatry, psychology, social work, clinical counseling, addiction medicine and counseling; or family and marriage counseling.

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

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

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

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

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

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

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

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

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

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

Hospice means services designed for and provided to *members* who are diagnosed with a terminal condition and are in a *hospice* inpatient program or in a home setting, as certified by a *participating physician*.

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

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

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

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

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

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

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

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

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

Maximum out-of-pocket amount means the maximum amount a *member* must pay towards *covered services* in the form of *cost sharing* in a given plan year. Once the *maximum out-of-pocket amount* is reached, we will pay one hundred percent of the allowed amount for *covered services* received under this *policy*. A *member's deductible* amount, prescription drug deductible amount (if applicable), *copayment* amounts and *coinsurance* amounts all contribute towards the *maximum out-of-pocket amount*. The individual and family *maximum out-of-pocket amounts* are shown in your *Schedule of Benefits*.

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

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

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

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

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

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

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

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

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

Mental health or Substance use disorder services means:
1. Professional services, including *inpatient* and *outpatient* services and *prescription drugs*, provided in accordance with *generally recognized standards of care* for the identification, prevention, treatment, minimization of progression, *habilitation* and *rehabilitation* of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including *substance use disorder*; or
2. Professional talk therapy services, provided in accordance with *generally recognized standards of care,* provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act.

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

TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Necessary medical supplies mean medical supplies that are:

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

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

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

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

Non-elective cesarean section means:

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

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

Notice and consent means the conditions that must be met in order for a *member* to waive *balance billing protections* as permitted by the federal No Surprises Act and New Mexico law. *Notice and consent* occurs only when each of the following conditions is met:

1. The *non-participating provider* provides the *member* a written notice in the format required by *applicable law* that states the provider is a *non- participating provider*, includes a good-faith estimate of the *non-participating provider's* charges for the services, identifies any prior authorization or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional and the *member* may seek care from a *participating provider*.
2. The *non-participating provider* provides the notice described above to the *member* at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least 3 hours before the services are furnished.
3. The *member* provides written consent to be treated by the *non-participating provider*

that includes the following:

a. The *member*'s acknowledgement that they have been provided written notice as described above and informed that payment of the *non-participating provider's billed amount* may not accrue toward the *member's deductible* or *maximum out-of-pocket amount*;
b. The *member's* statement that by signing the consent, they agree to be treated by the *non-participating provider* and understand they may be *balance billed* and subject to *cost-sharing* that applies to *non- participating providers*; and
c. The time and date on which the *member* received the written notice and signed the consent to receive services from the *non-participating provider*.

4. The *member's* consent is provided voluntarily, obtained by the *non-participating provider* in the format required by *applicable law*, and not revoked by the *member* before the services are provided.
5. The *non-participating provider* provides the *member* the notice document and the consent document together, but physically separate from other documents.
6. The *non-participating provider* provides the *member* a copy of the signed written *notice and consent* through email or mail.

Notice and consent will not waive *balance billing protections* for emergency services, air ambulance services, services furnished due to unforeseen and urgent medical needs, services provided by a *non-participating provider* when there is no *participating provider* available at the facility, or ancillary services (which are services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; diagnostic services such as radiology and laboratory services; and services provided by non-physician practitioners, assistant surgeons, hospitalists, and intensivists). *Notice and consent* will waive *balance billing protections* for *post-stabilization services* only if all the following additional conditions are met:

1. The attending emergency physician or treating provider determines the *member* is able to travel using nonmedical transportation or nonemergency medical transportation to an available *participating provider* or facility located within a reasonable travel distance, taking into consideration the *member's* medical condition.
2. The *member* (or the *member's* authorized representative) is in a condition to provide *notice and consent* as determined by the attending physician or treating provider using appropriate medical judgment.
3. The *non-participating provider* satisfies any additional requirements or prohibitions as may be imposed under applicable state law.

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

Other plan means any plan or *policy* that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, *health maintenance*

organization subscriber contracts, self-insured group plans, prepayment plans, and *Medicare* when the *member* is enrolled in *Medicare*. *Other plan* will not include Medicaid.

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

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

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

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

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

Post-stabilization services means services furnished after an enrollee's *emergency condition* is *stabilized* and as part of outpatient observation or an *inpatient* or *outpatient stay* with respect to the visit in which other *emergency services* are furnished.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rescission of a *policy* means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a *rescission* if: the cancellation or discontinuance of *coverage* has only a prospective effect; or the cancellation or

discontinuance of *coverage* is effectively retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of *coverage*.

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

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

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

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

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

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

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

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

Specialist or ***specialist provider*** 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, or treat certain types of symptoms and conditions related to their specific field of expertise.

Spouse means your lawful wife or husband.

Stabilize *means*, with respect to a *member* who has experienced an *emergency condition*, that the *member* is no longer experiencing further deterioration as a result of a prior illness or injury and there are no acute changes in physical findings, laboratory results, or radiologic results

that necessitate acute medical care. Acute medical care does not include acute rehabilitation. *Stabilize*, with respect to a member who has experienced an emergency 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* of the member to another facility or discharge of the member (*See Ambulance Services Benefits provision under the Major Medical Expense Benefit section).

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

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

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

Supplemental breast examination means a *medically necessary* and appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is: (a) used to screen for breast cancer when there is no abnormality seen or suspected; and (b) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

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.

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

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

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

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

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

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term *third party* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. The term *third party* includes any insurance company with a policy under which the *member* is entitled to benefits as a named insured person or an insured dependent *member* of a named insured person.

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

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

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

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

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

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

1. To prevent serious deterioration of a *member's* health; and

2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

Urgent care situation means a situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

1. The life or health of the *covered person* would otherwise be jeopardized;
2. The *covered person*'s ability to regain maximum function would otherwise be jeopardized;
3. In the opinion of a *physician* with knowledge of the *covered person*'s medical condition, delay would subject the *covered person* to severe pain that cannot be adequately managed without care or treatment;
4. The medical exigencies of the case require expedited care; or
5. The *covered person*'s claim otherwise involves *urgent care*.

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

Virtual 24/7 Care means a *telehealth services* benefit for virtual urgent care and virtual behavioral health provided to members through *the Ambetter-designated telehealth provider*. These services can be accessed through *the Ambetter-designated telehealth provider's* website.

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

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

Covered services for a newborn child include:

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

Additional premium will be required to continue coverage beyond the 31st *day* after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to us within the 31 calendar *days* from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 calendar *days* after the birth of the child. If notice is not given within the 31 calendar *days* from birth, we will charge an additional premium from the date of birth. If notice is given within 60 calendar *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 calendar *day* after its birth, unless we have received notice of the child's birth.

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

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

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

As used in this provision, *"placement"* means the earlier of:
1. The date that you or your *spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting you or your *spouse* custody of the child for the purpose of adoption.

Coverage for a Child Born Out of Wedlock
We will not deny enrollment of a child if the child's parent is covered under this *policy* on the grounds that:
1. The child was born out of wedlock;
2. The child is not claimed as a dependent on the parent's federal tax return; or
3. The child does not reside with the parent or does not reside in our *service area*.

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

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

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

ONGOING ELIGIBILITY

For All Members

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

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

For Dependent Members

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

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

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

Open Enrollment

Each year there will be an open enrollment period for coverage. The open enrollment period begins November 1, 2023 and extends through January 15, 2024. *Qualified individuals* who enroll on or before December 15, 2022 will have an *effective date* of coverage on January 1, 2024.

Special and Limited Enrollment

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

1. A *qualified individual* or *dependent* experiences a loss of *minimum essential coverage,* non-calendar year group or individual health insurance coverage, pregnancy-related

coverage, access to health care services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, or employee its instrumentalities as evaluated and determined by us. In such cases, we may take such action as maybe necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to us that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a chance in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, or an Alaskan native may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month;
11. A *qualified individual* newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA);
12. An enrollee loses access to their Marketplace plan as a result of death;
13. An enrollee loses access to their Marketplace plan as a result of divorce or legal separation;
14. Current employer plan no longer considered qualifying employer coverage;
15. An enrollee loses eligibility for Medicaid, *Medicare* or CHIP; or
16. An enrollee is a survivor of domestic violence, abuse or spousal abandonment.

Prior Coverage

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

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

PREMIUMS

Premium Payment

Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*, although an extension may be provided during the annual Open Enrollment period.

Grace Period

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 31 *day* grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify beWellNM, as necessary, of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period. A *member* is not eligible to re-enroll once terminated, unless a *member* enrolls during an annual open enrollment period or has a special enrollment period circumstance, such as a marriage or birth in the family.

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify us of your new *residence* within 60 calendar *days* of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the Special and Limited Enrollment provision for more information.

Misstatement of Tobacco or Nicotine Use

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

PRIOR AUTHORIZATION

Prior Authorization Requirement

Certain types of care require *prior authorization* from us.

This means that you or your provider must ask us to approve the care before you receive it.

A complete and current list of the services and prescription drugs that are subject to a prior authorization requirement can be found below.

We may decline payment for unauthorized care. If your *provider* is a *participating provider*, and you did not agree to receive unauthorized care, your *provider* cannot bill you for the care. If you received unauthorized care from a *provider* who is not a *participating provider* you may be fully responsible for the resulting bills.

We do not require *prior authorization* for:

1. Emergency services;
2. Contraception services that are not subject to any cost-sharing; or
3. An obstetrical or gynecological ultrasound.

However, we require *prior authorization* for continued *inpatient* care if you are admitted to a *hospital* for emergency treatment, but your condition is *stabilized*. You or your *provider* must notify us within one calendar *day* or as soon as reasonably possible from when you begin receiving emergency inpatient treatment, and within one calendar *day* or as soon as reasonably possible after the emergency ends and your condition *stabilizes*.

Prior Authorization Process

Your *participating provider* is responsible for knowing what care requires *prior authorization*, and for submitting a *prior authorization* request to us.

We will give any *provider* access to all necessary forms and instructions for making the request.

A *non-participating provider* is not required to submit a *prior authorization* request for you. If you visit one of these *providers*, and that *provider* will not submit a *prior authorization* request, you may submit a *prior authorization* request on your own behalf, or on behalf of a *dependent member*. We will help you obtain required documents and show you the guidelines that apply to the request. However, because your *provider* should be able to gather required information and submit it sooner, we encourage you to have your *provider* request *prior authorization* whenever possible.

Prior Authorization Review Timelines

If we do not deny a complete *prior authorization* request within these time frames the request is automatically approved:

1. **Urgent Care or Prescription Drugs –** If you require urgent medical care,

behavioral health care or a *prescription drug*, we will resolve the request within 24 hours.

2. **Non-Urgent Medicine –** If you do not have an urgent need for a *prescription drug*, we will resolve the request within three business *days* if your *provider*:
   a. Uses the *prior authorization* request form approved by the New Mexico Office of Superintendent of Insurance;
   b. Requests an exception from an established step therapy process; or
   c. Requests to prescribe a drug that we do not usually cover.
3. **Other Requests –** We will resolve all other requests within seven business *days*.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your *provider* might have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request it from your *provider*. Your *provider* will have at least four hours to *provide* requested information in connection with an urgent *prior authorization* request, and at least two calendar *days* for any other type of request.

Why We Review
Our review of a *prior authorization* request will determine if the proposed care involves a *covered service*, is *medically necessary* and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medical necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional.

Prior authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review
If you received care without a required *prior authorization*, we may allow your *provider* to request authorization retrospectively. Our utilization management team will assist your *provider* in the submission of a retrospective authorization request. However, we do not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request *prior authorization*.

Behavioral Health Care
Requests for *behavioral health* care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions.

Authorization Denial
We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process begins on page 131 of this document.

You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Services Requiring Prior Authorization

1. Adult accidental dental
2. Bariatric *surgery inpatient*
3. Bone anchored hearing aids
4. Cardiac *rehabilitation*
5. Cochlear implants
6. Corrective footwear orthotics shoes inserts
7. *Inpatient* services maternity care
8. Diabetic footwear
9. Diabetic footwear orthotics
10. *Durable medical equipment*
11. Hearing aid supplies batteries
12. *Home health care*
13. Imaging
14. Infertility diagnostic testing
15. Inherited metabolic disorder
16. *Inpatient facility* admission
17. Mastectomy bra
18. Neurodevelopmental therapy
19. Neurological *rehabilitation*
20. Outpatient mental health. **NOTE**: Excludes outpatient office visits and other services expressly provided for under the Mental Health and Substance Use Disorder Benefits provision.
21. Outpatient *surgery* doctor
22. Outpatient *surgery facility*
23. Private duty nursing
24. *Respite care*
25. Zero Cost Share/Preventative Drug (may require *prior authorization*)
26. Preferred Generic Drug (may require *prior authorization*)
27. Generic Drug (may require *prior authorization*)
28. Preferred Brand Drug (may require *prior authorization*)
29. Non-Preferred Generics and Brands Drug (may require *prior authorization*)
30. Specialty Drug (may require *prior authorization*)
31. *Non-participating specialist* visit
32. Skilled nursing *facility*
33. Sleep study
34. TMJ treatment
35. Transplant
36. Wigs

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

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

Copayments

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

Coinsurance Percentage

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

Maximum Out-of-Pocket
You must pay any required *copayment amounts* or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Summary of Benefits and Coverage*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *member*s' *eligible expenses*.

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

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

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

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

ACCESS TO CARE

Primary Care Practitioner (PCP)

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

1. Family practitioners
2. General practitioners
3. Internal medicine
4. Nurse practitioners*
5. Physician assistants
6. Obstetricians/gynecologists
7. Pediatricians (for children)
8. Doctors of oriental medicine
9. Chiropractic *physician*s
10. Certified nurse midwives

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

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

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

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

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

Changing Your Primary Care Practitioner (PCP)
You may change your *network PCP* by submitting a written request, online at our website, or by contacting our office at the number shown on your identification card. The change to your *network PCP* of record will be effective no later than 30 calendar *days* from the date we receive your request.

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

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

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

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

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

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

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

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

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

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

Continuity of Care
Under the federal No Surprises Act, if a *member* is a continuing care patient with respect to a *network provider* and the contractual relationship with the *provider* is terminated, such that the *provider* is no longer in the *network*; or benefits are terminated because of a change in the terms of the participation of the *provider*, as it pertains to the services the *member* is receiving as a *continuing care patient*, then we will:

1. Notify each *member* on a timely basis of the termination and their right to elect continued transitional care from the provider;
2. Provide the *member* with an opportunity to notify the health plan of the member's need for transitional care; and
3. Permit the *member* to elect to continue to have their benefits for the course of treatment relating to the their status as a *continuing care patient* during the period beginning on the date on which the notice described in (1) is provided and ending on the earlier of:

a. 90 *days* after the notice described in (1) is provided; or
b. The date on which such member is no longer a *continuing care patient* with respect to the provider.

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

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

Hospital Based Providers
When receiving care at a participating *hospital* it is possible that some hospital-based providers may not be *participating providers*. If you provide *notice and consent* to waive *balance billing protections*, you may be responsible for payment of all or part of the balance bill. Any amount you are obligated to pay to the *non-participating provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

Out-of-Network Care and Bills
If you receive care under any of the circumstances below from a *provider* who is not in your *network*, these are your rights:

If you receive emergency care out-of-network, including air ambulance service:
1. You are only responsible for paying what you would owe for the same care from an in-*network provider* or *facility*.
2. You do NOT need to get *prior authorization* for *emergency services*.
3. Your care can continue until your condition has *stabilized*. If you require additional care after stabilization, call Member Services and we will help you receive that care from an in-*network provider*.
4. You cannot be balance billed.

If you receive care from an out-of-network provider at an in-network facility, such as a hospital that is in your plan, you are only responsible for paying what you would owe for the same care from an in-*network* provider if:
1. You did not consent to services from an out-of-*network provider*,
2. Were not offered the service from an in-*network provider*, or
3. The service was not available from an in-*network provider* – as determined by your health care provider and your health insurance company.

If you get a bill from an out-of-network provider under any of the above circumstances that you do not believe is owed:
1. Call Member Services first. We will try to the resolve the issue with the provider on your behalf.
2. Contact the New Mexico Office of Superintendent of Insurance if the problem has not

been resolved by us – www.osi.state.nm.us or 1-855-4ASK-OSI (1-855-427-5674).

To help stop improper out-of-network bills, we will:

1. Notify you if your *provider* leaves our *network* and allow you transitional care with that provider at the in-*network* benefit level for up to 90 calendar days depending on your condition and course of treatment.
2. Verify the accuracy of our *provider* directory information at least every 90 calendar days.
3. Confirm whether a *provider* is in-*network* if you contact Member Services. If our representative provides inaccurate information that you rely on in choosing a *provider*, you will only be responsible for paying your in-*network* cost sharing amount for care received from that *provider*.

You have the right to receive notice of the following before you receive out-of-network care at an in-network facility:

1. A good faith estimate of the charges for out-of-*network* care.
2. At least five *days* to change your mind before you receive a scheduled out-of-*network* service. If you choose to receive out-of-*network* care you will be responsible for out-of-*network* charges that we do not cover.
3. A list of *participating providers* and the option to be referred to any such *provider* who can provide necessary care.

If you pay an out-of-network provider more than we determine you owe:

1. The *provider* will owe you a refund within 45 calendar *days* of receipt of payment by us.
2. If you do not receive a refund within that 45-*day* period, the *provider* will owe you the refund plus interest.
3. You may contact the New Mexico Office of Superintendent of Insurance at www.osi.state.nm.us and 1-855-4ASK-OSI (1-855-427-5674) for assistance or to appeal the provider's failure to provide a refund. You need to file the appeal within 180 calendar *days* of the 45-*day* refund period expiration.

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:

1. New technology
2. New medical procedures
3. New drugs
4. New devices
5. New application of existing technology

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our *members*. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we should change any of our benefits to include the new technology.

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

MAJOR MEDICAL EXPENSE BENEFITS

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

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

Benefit Limitation

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

Acquired Brain Injury Services

Benefits for *eligible expenses* incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition, if such services are necessary as a result of and related to an acquired brain injury and include:

1. Cognitive *rehabilitation therapy*,
2. Cognitive communication therapy,
3. Neurocognitive therapy and *rehabilitation*;
4. Neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment;
5. Neurofeedback therapy,
6. Remediation required for and related to treatment of an *acquired brain injury*,
7. Post-acute transition services and community reintegration services, including outpatient *day* treatment services or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an *acquired brain injury*.

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

scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

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

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

Ambulance Services

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

Ground and Water Ambulance Service Benefits

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

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

Note**:** Unless otherwise required by federal or New Mexico law, if you receive services from non-network ambulance providers, you may be *balance billed.*

Exclusions:
No benefits will be paid for:

1. Expenses incurred for *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
2. *Ambulance services* provided for a *member's* comfort or convenience.
3. Non-emergency transportation (for example, transport-van, taxi, ride sharing).

Air Ambulance Service Benefits
Covered services will include *ambulance services* for transportation by fixed wing and rotary wing air ambulance from home, scene of accident or *emergency condition*, subject to other coverage limitations discussed below:

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

Non-emergency air ambulance transportation requires *prior authorization. Prior authorization* is not required for air ambulance transportation, when the *member* is experiencing an *emergency condition*. **NOTE:** You should not be *balance billed* for covered air *ambulance services*.

Benefits for air *ambulance services* are limited to:

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

Exclusions:
No benefits will be paid for:

1. Air *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance services unless *prior authorization* is obtained.
3. Air ambulance services:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Air *ambulance services* provided for a *member's* comfort or convenience.

Autism Spectrum Disorder Benefits

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

Coverage is provided for *autism spectrum disorders* when prescribed by a physician or behavioral health practitioner and includes the following:

1. Evaluation and assessment services;
2. *Applied behavior analysis* therapy;
3. Behavior training and behavior management;
4. Speech therapy;
5. Occupational therapy;
6. Physical therapy;
7. Psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
8. Medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Bariatric Surgery

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

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 for which no equally or more effective standard treatment exists. 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 but only to the extent that the drug is paid for the manufacturer, distributor or provider of the drug,
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:
    a. The investigational item or service itself;
    b. 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
    c. Items and services customarily provided by the research sponsors free of charge for any *member* in the trial.
    d. Phase I and II clinical trials must meet the following requirements:
        i. 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

ii. The insured is enrolled in the clinical trial. This section shall not apply to insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Routine patient care costs are covered for members in a clinical trial if:

a. The clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.
b. The clinical trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention;
c. There is no non-investigational treatment equivalent to the clinical trial;
d. There is a reasonable expectation shown in clinical or pre-clinical data that the clinical trial will be at least efficacious as any non-investigational alternative; or
e. There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.
f. There is no non-investigational treatment equivalent to the clinical trial;
g. The available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative;
h. There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment; and
i. Routine patient costs outside of the state in which the individual resides.

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

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. An NIH Cooperative Group or Center;
6. The FDA in the form of an investigational new drug application;
7. The federal Departments of Veterans' Affairs, Defense, or Energy;
8. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
9. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Participation in clinical trials is subject to *prior authorization* requirements as outlined in this

policy.

Medical service or treatment that is a benefit under this plan that would be covered if the patient were receiving standard cancer treatment or other treatment for a life threatening medical condition.

Limitations: The following limitations apply.

a. Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial.
b. We shall not provide benefits that supplant a portion of a clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
c. In no event shall we be responsible for out-of-state or out-of-*network* costs unless we pay for standard treatment out of state or out of *network*. In no event shall we be responsible for out-of-state costs for any trials undertaken for the purposes of the prevention of or the prevention of reoccurrence of cancer or other life threatening illness.

The following are not covered:

a. Costs of the clinical trial that are customarily paid for by the government, biochemical, pharmaceutical or medical device industry sources
b. The cost of a non-FDA approved investigational drug, device, or procedure
c. The cost of a non-health care service the patient is required to receive as a result of participation in the clinical trial
d. Costs associated with managing the research that is associated with the clinical trial
e. Costs that would not be covered if non-investigational treatments were provided
f. Costs of tests that are necessary for the research of the clinical trial
g. Costs paid for or not charged by the clinical trial *providers*

Contraceptive Coverage

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

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

Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasounds, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management are covered

Covered Contraceptive Methods

Your plan covers these contraceptive methods:

1. Sterilization *surgery* for women
2. Sterilization *surgery* for men
3. Intrauterine device (IUD) copper
4. Intrauterine device (IUD) with progestin
5. Implantable rod
6. Shot/Injection
7. Oral contraceptives (the "pill") (combined "pill")
8. Oral contraceptives (extended/continuous use)
9. Oral Contraceptives (mini "pill" – progestin only)
10. Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches. This benefit requires coverage of a sufficient number and assortment to reflect the variety of oral contraceptives approved by the federal food and drug administration
11. Patch
12. Vaginal contraceptive ring
13. Diaphragm with spermicide
14. Sponge with spermicide
15. Cervical cap with spermicide
16. Male condom
17. Female condom
18. Spermicide
19. Emergency contraceptive – "Plan B"
20. Emergency contraceptive – "Ella"

Long-Acting Reversible Contraceptives

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

Oral Contraceptives

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

Six Month Dispensing

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

management.

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

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

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

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

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

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

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

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

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

Coronavirus; COVID-19 Public Health Emergency

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

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

Cytological Screening

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

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, non-insulin-using diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). *Covered services* include, but are not limited to:

1. Diabetes education and self-management training that shall be provided by a certified, registered or licensed health care professional who is approved to provide diabetes education; including;
    a. Medically necessary visits upon the diagnosis of diabetes;
    b. Visits following a diagnosis from a health care practitioner that represents a significant change in the *member's* symptoms or condition that warrants changes in the *member's* self-management;
    c. Visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority;
    d. Telephonic visits with certified diabetes education
    e. Medical nutrition therapy related to diabetes management
2. Examinations including podiatric examinations;
3. Routine foot care such as trimming of nails and corns;
4. Laboratory and radiological diagnostic testing and self-management equipment.

Covered services include diabetes supplies such as:

1. Insulin pumps when medically necessary, prescribed by a *provider*;
2. Prescriptive diabetic oral agents for controlling blood sugar levels;
3. Blood glucose monitors, including those for the legally blind and individuals with disabilities;
4. Test strips for blood glucose monitors;
5. Visual reading urine and ketone strips;
6. Lancets and lancet devices;
7. Insulin;

8. Injection aids, including those adaptable to meet the needs of the legally blind and individuals with disabilities;
9. Specialized monitors/meters for the legally blind;
10. Syringes;
11. Prescriptive oral agents for controlling blood sugar levels'
12. *Medically necessary* podiatric appliances for prevention of feet complications associated with diabetes, including corrective footwear, therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment, and one pair of foot orthotics per year per covered person
13. *Medically necessary durable medical equipment*, such as glucometers; and
14. Glucagon emergency kits.

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

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

When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the federal Food and Drug Administration, we will:

1. Maintain an adequate formulary to provide these resources to *members* with diabetes; and
2. Guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the *policy*.

If you pay out of pocket for *medically necessary* equipment, appliances, supplies and insulin or other prescription drugs described in this section that are not delivered timely, we will reimburse you within 30 *days* following your written request for reimbursement, or else pay 18% annual interest for any reimbursements after 30 *days*.

Unless your diabetes diagnosis or treatment changes, we will not require more than one prior authorization per year for any *covered services* identified above.

Covered services related to diabetes may be subject to *deductibles* and *coinsurance* consistent with those imposed on other benefits under this *policy*. The annual *deductibles* or *coinsurance* for these benefits will be no greater than the annual *deductibles* or *coinsurance* established for similar benefits within this policy.

Dialysis Services

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

Covered services include:

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*;
4. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

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

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

1. The equipment, supply, or appliance is a *covered service*;
2. The continued use of the item is *medically necessary*;
3. It is necessary due to a change in the *member's* condition, wear or after the product's normal life expectancy has been reached;
4. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification);
5. Repair or replacement is required by state law; and
6. One-month rental of a wheelchair is covered if the *member* owned the wheelchair that is

being repaired.

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 a network *durable medical* equipment 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.

Disposable Medical Supplies

Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to, bandages and wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes and applicators. Surgical dressings that require a *provider's* prescription and cannot be purchased over the counter are covered when *medically necessary* for the treatment of a wound caused by, or treated by, a surgical procedure The supplies are subject to the *member's* medical *deductible amount*, *copayment amount* and/or *coinsurance amount.*

Durable Medical Equipment

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

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

1. Equipment that is *medically necessary* for the treatment of an illness or *accidental injury* or to prevent further deterioration.

2. Equipment that is designed for repeated use, including oxygen equipment, functional wheelchairs, and crutches.
3. Equipment that is considered standard and/or basic for the treatment of an illness or accidental injury as defined by nationally recognized guidelines.
4. Hemodialysis equipment.
5. Pressure machines.
6. Infusion pump for IV fluids and medicine.
7. Glucometer.
8. Tracheotomy tube.
9. Cardiac, neonatal, and sleep apnea monitors.
10. Augmentative communication devices are covered when we *approve* based on the *member's* condition.

Exclusions:
Non-covered items may include, but are not limited to:
1. Air conditioners.
2. Ice bags/cold pack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a *facility* that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

All types of *durable medical equipment* and supplies are subject to *prior authorization* as outlined in this *policy*. See your *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.

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

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

Exclusions:
Non *covered services* and supplies include, but are not limited to:
1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.

4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive Care Expense Benefits provision).
6. Medijectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Prosthetics and Orthotics

This plan provides coverage for initial and secondary prosthetic devices and custom orthotics in a non-discriminatory manner, and without restriction based on predetermined utilization limits, at the same level and *cost-sharing* as the coverage provided for medical and surgical benefits. Prosthetic and custom orthotic devices are considered *habilitative* and *rehabilitative* essential health benefits and are not subject to separate financial requirements or utilization restrictions. Coverage includes:

1. Clinical care
2. All supplies, materials, and devices determined by the *physician* to be *medically necessary* and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming, strength training.
3. All services, including design, fabrication, and repair
4. Replacement, without regard to reasonable useful lifetime restrictions, including replacement necessary due to a change in the patient's condition or the condition of the device if replacement the device requires repairs costing more than 60 percent of replacement cost
5. Access to prosthetic and custom orthotic devices from at least two distinct device providers in your *network*.

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Prosthetic and custom orthotic benefits will not be denied for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity. However, coverage for prosthetic devices and custom orthotics will not be provided when required solely for comfort or convenience.

Family, Infant and Toddler (FIT) Program

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

the FIT Program Early Intervention Services under New Mexico law.

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

Family Planning and Contraception Services

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

1. Implantable rods,
2. Copper intrauterine devices,
3. Intrauterine devices with progestin (all durations and doses),
4. Injectable contraceptives,
5. Oral contraceptives (combined pill),
6. Oral contraceptives (progestin only),
7. Oral contraceptives (extended or continuous use),
8. The contraceptive patch,
9. Vaginal contraceptive rings,
10. Diaphragms,
11. Contraceptive sponges,
12. Cervical caps,
13. Condoms,
14. Spermicides,
15. Emergency contraception (levonorgestrel) and
16. Emergency contraception (ulipristal acetate).

Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient’s attending provider have determined it to be medically appropriate).

Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).

Instruction in fertility awareness-based methods, including lactation amenorrhea. Services that are integral to the furnishing of the above-listed coverage (e.g., anesthesia provided during sterilization surgery), are also included under preventive care, regardless of whether the service is billed separately.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

1. *Covered services* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be determined *medically necessary*.
3. *Covered services* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the United States Food and Drug Administration.
4. *Covered services* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient rehabilitative physical therapy, occupational therapy, and speech therapy.
6. Coverage for Cardiac and Pulmonary Rehabilitation

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

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

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

Home Health Care Service Expense Benefits

Covered services and supplies for *home health care* are covered when your *physician* indicates you are not able to travel for appointments to a medical office. *Home health care* services and benefits are subject to *prior authorization* requirements as outlined in this *policy*. Coverage is provided for *medically necessary network* skilled intermitted health care services provided by a registered nurse or a licensed practical nurse; physical occupational, and/or respiratory therapist and/or speech pathologist. and is provided at the *member's* home and includes the following:

1. *Home health aide services*, only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Services of a private duty registered nurse or licensed practical nurse rendered on an outpatient basis. Please refer to your *Summary of Benefits and Coverage (SBC)* for any limits associated with this benefit.
3. Medical drugs. Medical drugs are defined as medications administered in the office, infusion suite, or facility (including *home health care*) that require a health care

professional to administer. These medications include, but are not limited to, injectable, infused, oral or inhaled drugs. Infusion therapy is included.
4. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.* Please refer to your *Summary of Benefits and Coverage (SBC)* for any limits associated with this benefit.
5. Intravenous (I.V.) medication and pain medication.
6. Hemodialysis, and for the processing and administration of blood or blood components.
7. *Necessary medical supplies*, drugs and medicines, and laboratory services, to the extent they would have been covered if provided to the *member* on an impatient basis.
8. Rental of *medically necessary durable medical equipment* at the discretion of the plan. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.
9. Collection of specimens to be submitted to an approved laboratory facility for analysis
10. Total parenteral and enteral nutrition as the sole source of nutrition.

Intravenous (I.V.) medication and pain medication are *covered services* to the extent they would have been *covered service*s during an *inpatient hospital* stay. At our option, we may *authorize* the purchase of the equipment from a *participating provider* in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we *authorize* before the purchase.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care under the Home Health Care Service Expense Benefit.

Hospice Care Service Expense Benefits

This provision only applies to a terminally ill member receiving *medically necessary* care under a hospice care program or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member*. Respite days that are applied toward the *deductible* are considered *covered services* and shall apply against any maximum benefit limit for these services. See the *Summary of Benefits and Coverage* for benefit levels or additional limits.

The list of *covered service expenses* is expanded to include:
1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. Physical therapy.
5. The rental of medical equipment while the *terminally ill covered person* is in a *hospice* care program to the extent that these items would have been covered under the *policy* if the *member* had been confined in a *hospital.*
6. Medical supplies.
7. Prescription drugs and medication for the pain and discomfort specifically related to the terminal illness.

8. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
9. Medical transportation
10. Counseling the *member* regarding his or her *terminal illness.*
11. *Terminal illness counseling* of the *member's immediate family.*
12. *Bereavement counseling.*
13. In-home *hospice* care and *home health care* services.

Benefits for *hospice* inpatient, home or outpatient 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.

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

Hospital Benefits

Covered services are limited to charges made by a *hospital* for:
1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate. Includes meals and special diets or parenteral nutrition when *medically necessary.*
2. A private *hospital* room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. General nursing care.
5. Use of all *hospital facilities* when use of such *facilities* is determined to be *medically necessary* by the covered person's *primary care practitioner* or treating health care professional.
6. *Inpatient* use of an operating, treatment, or recovery room.
7. Outpatient use of an operating, treatment, or recovery room for *surgery.*
8. *Physician* and surgeon services.
9. Special duty nursing when *medically necessary.*
10. Radiation therapy, inhalation therapy, and administration of whole blood and blood components when *medically necessary.*
11. Services and supplies, including anesthesia, oxygen services, drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
12. *Emergency* treatment of an *illness* or *injury*, even if confinement is not required. See your *Summary of Benefits and Coverage (SBC)* for *limitations*.

Emergency Room Services

If you experience an *emergency condition,* you should call 911 or head straight to the nearest emergency room. We cover *emergency services* both in and out of our *service area*. We cover these services 24 hours a *day*, seven *days* a week.

Note: Some providers that provide *emergency services* may not be in your *network*. These services are subject to *balance billing protections* and the *non-participating provider* may not *balance bill* you for the difference between our *allowed amount* and the provider's *billed amount*.

Long Term Acute Care (LTACH)
Long-term acute care *hospitals* (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods when *medically necessary* and approved by us. LTACH benefits are subject to *prior authorization* requirements as outlined in this *policy*.

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

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

a. Failed weaning attempts at an acute care facility
b. Patient has received mechanical ventilation for 21 consecutive *days* for 6 hours or more/per *day*
c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
e. Patient is hemodynamically stable and not dependent on vasopressors
f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
g. 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.

Infertility Treatment

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

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

Lymphedema Benefit

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

Mammography

Routine screenings are covered at no *cost share* for *diagnostic breast examinations*, and *supplemental breast examinations. Diagnostic breast examinations* are performed to examine the breast tissue more closely, typically following symptoms or after a screening mammogram show suspicious results. Coverage shall include screenings at the following intervals: one baseline breast cancer screening mammography for *persons* between the ages of 35 and 39 years; one screening mammogram every two years, or annually, for all persons ages 40 through 49; and one mammogram per year for all persons 50 years of age and over. In addition, coverage for diagnostic mammography will be provided to any member, regardless of

age, who has been diagnosed with breast cancer, when such services are referred by a *medical practitioner* acting with the scope of the practitioner's license.

Maternity Care

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

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

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

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

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

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

Duty to Cooperate

We do not *cover* services or supplies related to a *member*'s *pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar *days* of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to

Ambetter from Western Sky Community Care, Inc. at Member Services, 5300 Homestead Road NE Albuquerque, NM 87110. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this provision on the basis of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

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

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

Medical and Surgical Expense Benefits
Covered services provided under this provision are subject to all other terms and conditions of the *policy*, including *deductible amount* and *cost sharing* provisions. *Covered services* include, but are not limited to, *prior authorizations* and charges:

1. For *surgery* in a *physician's* office, an *inpatient* facility, an outpatient facility or a surgical facility, including services and supplies
2. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures. The tests must be for the same bodily *illness* or *injury* causing the *member* to be *hospitalized* or to have the outpatient *surgery* or procedure.
    b. Bone density studies
    c. Clinical laboratory tests
    d. Gastrointestinal laboratory procedures
    e. Pulmonary function tests
    f. Genetic testing

g. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing

3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
5. For *durable medical equipment*, *prosthetic devices*, *orthotic devices* or other necessary medical supplies following a medical or surgical procedure such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics provision of this *policy*.
6. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
7. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
8. For hyperbaric oxygen therapy only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS), or as *medically necessary.*
9. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to*:*
    a. Charges for all stages of rreconstructive breast *surgery* as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with all other physical complications resulting from the mastectomy including lymphedema.
    b. Reconstructive *surgery* for craniofacial abnormalities.
10. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. 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*:
        i. A *member* whose treating *medical practitioner* in consultation with the dentist, determines the *member* has a significantly complex dental condition

or a developmental disability in which patient management in the dental office has proved to be ineffective; or

ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the *member* during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.

iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.

11. For infertility counseling and planning services when provided by a *participating* provider and testing to diagnose infertility.
12. For the treatment of breast cancer by dose-intensive chemotherapy 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 bone marrow transplants or stem cell transplants.
13. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *policy*. See the Clinical Trial Coverage provision of this *policy*.
14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants
    b. Artery or vein grafts
    c. Heart valve grafts
    d. Prosthetic tissue replacement, including joint replacements
    e. Implantable prosthetic lenses, in connection with cataracts
    f. Skin grafts
15. For X-rays, Magnetic Resonance Imaging (MRI), Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *policy*.
16. For *medically necessary telehealth services. Telehealth services* not provided by *Ambetter Telehealth* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in-person.
17. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
18. For *medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see Habilitation, Rehabilitation and Extended Care Facility Expense Benefits provision of this *policy.*
20. 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.

21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *participating* provider.
23. For *medically necessary* biofeedback services.
24. For *medically necessary* nutritional counseling, *prior authorization* may be required.
25. For therapeutic abortion performed to save the life or health of the *member,* or as a result of incest or rape, to the extent the abortion is legal under *applicable law*.
26. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedures.
27. For *medically necessary* chiropractic care and acupuncture treatment on an outpatient basis only. *Cost sharing* for *chiropractic* care services shall not exceed the *cost sharing* imposed for primary care service.
28. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
29. For all *medically necessary* immunizations, monitoring, screenings, re-screenings and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
30. For *medically necessary* allergy testing and treatment including allergy injections and serum.
31. For *medically necessary* biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing care of a *member's* disease or condition. Coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples. You and your *provider* will have clear, accessible and convenient processes to request an appeal of a benefit denial. You can find those processes on our website.
32. For *medically necessary* osteoporosis coverage for services related to the treatment and appropriate management of osteoporosis

If your provider has the capability, your coverage will include online visit services. *Covered services* include a medical consultation using the internet via a webcam, chat or voice. Non-covered services include, but are not limited to, communications used for:

1. Reporting normal laboratory or other test results
2. Office appointment requests
3. Billing, insurance coverage or payment questions
4. Requests for referrals to doctors outside the online care panel
5. Benefit precertification
6. Physician to physician consultation

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

Medical Dental Services

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

Coverage is also provided for:

1. *Medically necessary* oral *surgery*, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is *medically necessary* to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental injuries.
    d. Treatment for Temporomandibular Joint (TMJ) disorder, including removable appliances for TMJ repositioning and related surgery, medical care and diagnostic services.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are medically necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a *network hospital*, surgical center or office, provided to the following *members*:
    a. A *member* under the age of 19;
    b. A person who is severely disabled; or
    c. A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
    d. Dental service expenses when a member suffers an injury, that results in damage to his or her natural teeth. Injury to the natural teeth will not include any injury as a result of chewing.
3. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders or malocclusions.

Medical Foods

We cover medical foods and formulas for:

1. Outpatient total parenteral nutritional therapy

2. Nutritional counseling
3. Nutritional supplements for prenatal care when prescribed by a *provider* for pregnant women
4. Nutritional supplements that require a prescription to be dispensed are covered when prescribed by *provider* and when *medically necessary* to replace a specific documented deficiency
5. Nutritional supplements administered by injection at the *provider's* office are covered when *medically necessary*
6. Outpatient elemental formulas for malabsorption
7. Dietary formula (when medically necessary and prescribed by a *participating* medical practitioner/provider and administered by enteral tube feedings or when medically necessary for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism)
8. Outpatient elemental formulas for malabsorption

Coverage includes diagnosing, monitoring, and controlling disorders of genetic inborn errors of metabolism. This includes:

a. Nutritional and medical assessment
b. Clinical services
c. Biochemical analysis
d. Medical supplies
e. Prescription drugs/medications
f. Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of inborn errors of metabolism to compensate for the metabolic abnormality and to maintain adequate nutritional status. Special medical foods may be prescribed for other *medically necessary* conditions.

Coverage also includes other heritable diseases, regardless of the formula delivery method. 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. 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.

In addition, inpatient and outpatient benefits will be provided for up to two months for medically necessary pasteurized donor human milk when prescribed by an infant's pediatrician or licensed pediatric provider stating that the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding or the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities.

Exclusions: any other dietary formulas, food thickeners, oral nutritional supplements, unless otherwise described in this section, special diets, prepared foods/meals and formula for access problems.

Low-Protein Food Products for Treating Inherited Metabolic Diseases

Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-

protein food products are foods that are especially formulated to have less than 1 gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

Benefits for low-protein food products are limited to treating the following diseases:

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

Medical Vision Services

Covered services include:

1. Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
2. Vision screenings to determine the presence of refractive error.
3. *Members* who have been diagnosed with diabetes may self-refer once each year to an eye care *specialist provider* 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 provider* may require a referral through your *participating provider*.

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

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

Mental Health and Substance Use Disorder Benefits

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

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

Covered services will be provided on an inpatient and outpatient basis for the treatment of mental health and substance use disorder diagnoses. If you need *mental health* and/*or substance use disorder* treatment, you may choose any *provider* participating in our mental health *network* and do not need a referral from your *PCP* in order to initiate treatment. *Deductible amounts, copayment* or *coinsurance* amounts and treatment limits for covered *mental health* and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

When making coverage determinations, our *behavioral health* Utilization Management staff utilizes established level of care guidelines and medical necessity criteria that are based on *generally recognized standards of care* and take into account legal and regulatory requirements. Our *behavioral health* staff utilizes InterQual criteria for *mental health* and *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. The duration of coverage for an insured with a *mental health* or *substance use disorder* shall be based on the *mental health* or *substance use disorder* needs of the insured rather than on arbitrary time limits.

When in-*network* access to *mental health* or *substance use disorder* services are not reasonably available, we will provide access to out-of-*network* services with the same cost-sharing obligations to you as those required for in-*network* services

Except in cases in which the insured terminates a plan, we shall not terminate coverage of services without consultation with the insured's *mental health* or *substance use disorder services provider*.

We shall not rescind or modify an authorization for *mental health* or *substance use disorder services* that has been authorized, after the *provider* renders the services pursuant to a determination of *medical necessity*, in good faith, except for cases of fraud or violation of the *provider's* contract with us.

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

Inpatient

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

Outpatient

1. Individual and group therapy for *mental health disorders* and *substance use disorders*;

2. Medication management services;
3. Outpatient detoxification programs;
4. Psychological and Neuropsychological testing and assessment;
5. *Applied behavior analysis* treatment for *autism spectrum disorders*;
6. *Telehealth* (individual/family therapy; medication monitoring; assessment and evaluation);
7. Partial Hospitalization Program (PHP);
8. Intensive Outpatient Program (IOP);
9. Mental health day treatment;
10. Electroconvulsive Therapy (ECT);
11. *Transcranial Magnetic Stimulation (TMS)*;
12. Evaluation and assessment for *mental health disorder* and *substance use disorder*; and
13. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*.

Expenses for these services are covered if *medically necessary* and may be subject to *prior authorization in consultation with our mental health* or *substance use disorder* service *provider.*

NOTE: In accordance with Senate Bill 273, *prior authorization* is not required for the following services:

1. Acute or immediately necessary care;
2. Acute episodes of chronic *mental health* or *substance use disorder* conditions;
3. Initial in-network *inpatient* or outpatient substance use treatment services;
4. *Outpatient substance use* treatment services that are not of an intermediate *medically necessary* level of care; or
5. Medication approved by the FDA prescribed for the treatment of a *substance use disorder*, except in cases in which a generic version is available.

All *prior authorization* determinations for continuation of services in chronic or stable conditions, or additional services, will be in consultation with your *behavioral health provider*. Please see the *Summary of Benefits and Coverage (SBC)* for more information regarding services that require *prior authorization*.

In addition, Integrated Care Management is available for all of your health care needs, including *behavioral health* and *substance use disorders*. Please call Member Services to be referred to a care manager for an assessment.

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

Cost sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, *substance use disorders* and trauma spectrum disorders. This includes *cost sharing* for *inpatient*, detoxification, *residential*

treatment facility and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name drugs when generic are unavailable.

Cost sharing means any *copayment*, *coinsurance*, *deductible* or any other form of financial obligation of a *member* other than a premium or a share of a premium or any combination of any of these financial obligations

Outpatient Medical Supplies Expense Benefits

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

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

Pediatric Routine Vision Benefits

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

1. Routine ophthalmological examination
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Standard frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or
    e. Contact lenses (in lieu of glasses).
4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium);
    b. Intermediate vision lenses;
    c. Blended segment lenses;

d. Hi-Index lenses;
e. Plastic photosensitive lenses;
f. Photochromic glass lenses;
g. Glass-grey #3 prescription sunglass lenses;
h. Fashion and gradient tinting;
i. Ultraviolet protective coating;
j. Polarized lenses;
k. Scratch resistant coating;
l. Anti-reflective coating (standard, premium or ultra);
m. Oversized lenses;
n. Polycarbonate lenses.

5. Low vision evaluation/aids.

Please refer to your *Summary of Benefits and Coverage (SBC)* for a detailed list of *cost sharing,* annual maximum and appropriate service *limitation*s. To see which vision *providers* are part of the *network*, please visit Ambetter.WesternSkyCommunityCare.com or call Member Services.

Services not covered:

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

Pre-Exposure Prophylaxis (PrEP)

Your plan includes coverage for PrEP medication, as appropriate for you, and essential PrEP related services without cost-sharing, the same as any other preventive drug or service. This means that you do not have to make a co-payment, pay coinsurance, satisfy a deductible or pay out-of-pocket for any part of the benefits and services listed in this summary if you receive them from an in-network provider.

You may be required to pay a copay, coinsurance, and/or a deductible if you receive PrEP medication or PrEP related services from an out-of-network provider if the same benefit or service is available from an in-network provider.

What is Covered?

1. At least one FDA-approved PrEP drug, with timely access to the PrEP drug that is medically appropriate for the enrollee, as needed
2. HIV testing
3. Hepatitis B and C testing
4. Creatinine testing and calculated estimated creatine clearance or glomerular filtration rate
5. Pregnancy testing for individuals with childbearing potential
6. Sexually transmitted infection screening and counseling
7. Adherence counseling

8. Office visits associated with each preventive service listed above
9. Quarterly testing for HIV and STIs, and annually for renal functions, required to maintain a PrEP prescription

If you were charged cost-sharing for coverage of PrEP medication or PrEP related services on or after January 1st, 2021, please call Member Services. If the issue is not resolved at the customer service level use the below to contact our Grievance and Appeal Department. Please refer to the Summary of Health Insurance Grievance Procedures section for further details.

If you are denied coverage of a PrEP related service(s), we will inform you in writing of the denial. Our notice to you will explain why we denied the coverage and will provide you with instructions for filing a grievance if you want to contest our decision. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP coverage denial by a calling or writing to us.

Exception Process
If you have been denied coverage of a PrEP medication, we will inform you in writing of the denial. Our notice to you will provide you with instructions for filing an exception request if the medication that is most appropriate for your circumstances is not included in the drug formulary. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP medication coverage denial by calling or writing to us.

Standard Review

- We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 72 hours following receipt of your request.

Expedited Review

- If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a non-formulary drug, you can request an expedited review. We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 24 hours following receipt of your request.

If our initial determination is overturned, we will provide coverage for the PrEP medication or PrEP related service that is medically appropriate for you for the duration of the treatment.

For more information or assistance with your complaint, grievance or an exception request, you may contact the Managed Health Care Bureau (MHCB), of the Office of Superintendent of Insurance at:

Office of Superintendent of Insurance - Managed Health Care Bureau
P.O. Box 1689
Telephone: 1-505-827-4601

Prescription Drug Expense Benefits

We work with *providers* and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases. We will accept uniform *prior authorization* forms for *prescription drugs* as sufficient to request *prior authorization* for *prescription drug* benefits. If we fail to accept the uniform prior authorization form or respond within three business *days* for standard requests or 24 hours for urgent requests*,* the *prior authorization* request will be deemed granted.

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

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

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

Such *covered services* shall include those for prescribed, orally administered anticancer medications. The *covered services* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *policy*. The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*.

We will not require you to make a payment at the point of sale for a covered *prescription drug* in an amount greater than the least of the:

1. Applicable *cost-sharing* amount for the *prescription drug*;
2. Amount you would pay for the *prescription drug* if you purchased the *prescription drug* without using a health benefits plan or any other source of *prescription drug* benefits or discounts;
3. Total amount the pharmacy will be reimbursed for the *prescription drug* from us, including the *cost-sharing* amount paid by us; or

4. Value of the rebate from the manufacturer provided to us or our pharmacy benefits manager for the prescribed drug.

If a *prescription drug* rebate is more than the amount needed to reduce the insured's *copayment* to zero on a particular drug, the remainder shall be credited to us. Any rebate amount will be counted toward the out-of-pocket *prescription drug* costs.

Formulary or Prescription Drug List

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

NOTE: Not all dosage forms or strengths of a drug may be covered. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specified drug. Drugs listed on the formulary are selected by us based upon the recommendations of a Pharmacy and Therapeutics committee, which is made up of currently practicing *physicians* and pharmacists from across the country, some of whom are employed by or affiliated with us.

The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the formulary. Entire drug classes are also regularly reviewed. Some of the factors committee *members* evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List. Positive changes (e.g., adding drugs to the formulary, drugs moving to a lower payment tier) can occur quarterly after review by the committee.

Changes to the formulary that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or *prior authorization,* increasing the *cost-sharing copayment*, *deductible* or *co-insurance* charges for a drug, or imposing or modifying a drug's quantity limit) occur only annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the formulary may occur more frequently.

We may immediately and without prior notice remove a drug from the formulary if the drug

1. Is deemed unsafe by the federal food and drug administration; or
2. Has been removed from the market for any reason.

In the event that a drug is removed from the formulary, at least sixty days' advance written notice is required when it is determined that one of the following modifications will be made to a formulary:

1. Reclassification of a drug to a higher tier of the formulary
2. Reclassification of a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary
3. An increase in the *cost-sharing, copayment, deductible* or *coinsurance* charges for a drug
4. Removal of a drug from the formulary
5. Addition of a *prior authorization* requirement
6. Imposition or modification of a drug's quantity limit
7. Imposition of a step-therapy restriction for a 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.WesternSkyCommunityCare.com (under “For Member”, “Drug Coverage”) or call Member Services.

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

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

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

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

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

Mail Order Pharmacy

Mail Order Pharmacy offers a convenient way to receive your prescriptions. Eligible 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, please refer to our Ambetter website. Once on our Ambetter website, click on “For Members”, followed by “Drug Coverage”. Under the “Mail Order” section, you will find details on your in-network mail order pharmacies and next steps for enrollment.
The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *medical practitioner.*

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

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

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

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

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

1. An individual health insurance *policy*, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state and that provides a *prescription drug* benefit shall allow an insured to fill or refill a prescription for less than a 30 *day* supply of the *prescription drug,* and apply a prorated daily *copayment* or *coinsurance* for the fill or refill, if:
    a. The prescribing *practitioner* or the pharmacist determines the fill or refill to be in the best interest of the insured;
    b. The insured requests or agrees to receive less than a 30 *day* supply of the *prescription drug*; and
    c. The reduced fill or refill is made for the purpose of synchronizing the insured's

prescription drug fills.

2. An individual health insurance *policy*, health care plan or certificate of health insurance that offers a *prescription drug* benefit shall not:
   a. Deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions for the insured pursuant to Subsection A of this section established among the insurer, the prescribing *practitioner*, *practitioner*, insurer shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and
   b. Prorate a dispensing fee to a pharmacy that fills a prescription with less than a 30 *day* supply of *prescription drug* pursuant to Subsection A of this section. The insurer shall pay in full a dispensing fee for a partially filled or refilled prescription for each prescription dispensed, regardless of any prorated *copayment* or *coinsurance* that the insured may pay for prescription synchronization services.

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

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

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

Non-Covered Services and *Exclusion*s:
No benefits will be paid under this benefit provision for services provided or expenses incurred:
1. For immunization agents otherwise not required by the Affordable Care Act.
2. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
3. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
4. For a refill dispensed more than 12 months from the date of a *physician's* order.

5. For weight loss *prescription drugs*, unless otherwise listed on the formulary;
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
8. For drugs labeled “Caution – limited by federal law to investigational use” or for *investigational* or *experimental* drugs.
9. For more than a 30-*day* supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-*day* supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-*day* supply when dispensed by retail or mail order. **NOTE:** Only the 90-*day* supply is subject to the discounted *cost sharing* mail orders less than 90 *days* are subject to the standard *cost sharing* amount.
10. For *prescription drugs* for any *member* who enrolls in *Medicare* Part D as of the date of his or her enrollment in *Medicare* Part D. *Prescription drug* coverage may not be reinstated at a later date.
11. For any drug that we identify as therapeutic duplication through the Drug *Utilization Review* program.
12. For drugs or dosage amounts determined by Ambetter Pharmacy and Therapy committee to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
13. Foreign Prescription Medications, except those associated with an *emergency* medical condition while you are travelling outside the United States. These *exceptions* apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
15. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status.
16. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
17. For any injectable medication or biological product that is not expected to be self-administered by the *member* or *member’s* place of *residence* unless listed on the formulary.
18. Medication refills where a *member* has more than 15 *days*’ supply of medication on hand.
19. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
20. For any drug related to dental restorative treatment or treatment of chronic periodontitis where drug administration occurs at dental practitioner’s office.
21. For any drug related to *surrogate pregnancy*.
22. For medications used for cosmetic purposes.
23. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless such treatment is listed on the formulary.

24. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation for out of country travel.

Step Therapy Protocol

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

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

In the absence of clinical guidelines that meet the requirements above, peer-reviewed publications may be substituted. Our Pharmacy and Therapeutics committee will review and approve all such protocols. Step therapy will not be required before authorizing coverage for medication approved by the FDA that is prescribed for the treatment of a *substance use disorder*, pursuant to a *medical necessity* determination, except in cases in which a *generic* version is available.

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

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

We shall expeditiously grant an exception to the step therapy protocol, based on *medical necessity* and a clinically valid explanation from the patient's prescribing *practitioner* as to why a drug on the formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if

1. The *prescription drug* that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;
2. The *prescription drug* that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the *prescription drug* regimen;
3. While under the insured's current health insurance policy, health care plan or certificate of insurance, or under the insured's previous health coverage, the insured has tried the *prescription drug* that is the subject of the exception request or another *prescription drug* in the same pharmacologic class or with the same mechanism of action as the *prescription drug* that is the subject of the exception request and that *prescription drug* was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or
4. The *prescription drug* required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the *prescription dru*g is expected to:
    a. Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
    b. Worsen a comorbid condition of the patient; or
    c. Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

External exception request review

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

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

Preventive Care Expense Benefits

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

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed *preventive care* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional *preventive care* and screenings as provided for in comprehensive guidelines supported by the HRSA.

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

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

Our Ambetter Health Preventive Services Guide is updated annually and contains detailed information regarding preventive care coverage available to you. It is accessible via our website Ambetter.WesternSkyCommunityCare.com or by contacting Member Services. Either go to the website directly or if you need to request a paper copy, please contact Member Services for assistance.

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

1. Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;
2. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 35 to 70 years who are overweight or obese;
3. Anxiety Disorder in Adults: Screening;
4. Asymptomatic Bacteriuria in Adults: Screening: pregnant persons;
5. BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation;
6. Breast Cancer: Medication Use to Reduce Risk: persons at increased risk for breast cancer;
7. Breast Cancer: Screening: persons aged 40 and older;
8. Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children;
9. Cervical Cancer: Screening: women aged 21 to 65 years;
10. Colorectal Cancer: Screening: adults aged 45 to 75 years, including related services (e.g. *specialist* consultations, required preparation, anesthesia, polyp removal and pathology services);
11. Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
12. Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
13. Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;

14. Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;
15. Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of *pregnancy*;
16. Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation;
17. Chlamydia and Gonorrhea: Screening: sexually active women;
18. Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling: adults who are overweight or obese and have additional cvd risk factors;
19. Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;
20. Hepatitis B Virus Infection: Screening, 2014: persons at high risk for infection;
21. Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
22. High Blood Pressure in Adults: Screening: adults aged 18 years or older;
23. Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
24. Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
25. Hypertension in Adults: Screening;
26. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
27. Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
28. Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality from Preeclampsia: Preventive Medication: pregnant women who are at high risk for preeclampsia;
29. Lung Cancer: Screening: adults aged 50-80, with a history of smoking;
30. Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;
31. Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
32. Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
33. Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
34. Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
35. Preeclampsia: Screening: pregnant woman;
36. Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
37. Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women;
38. Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
39. Sexually Transmitted Infections: *Medically necessary* treatment of Sexually Transmitted Infections (STIs), and screening, testing, examining, counseling, and administering or dispensing treatments to prevent STIs;

40. Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children;
41. Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10 percent or greater;
42. Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
43. Syphilis Infection in Pregnant Women: Screening: pregnant women;
44. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
45. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women;
46. Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
47. Unhealthy Drug Use: Screening: adults age 18 years or older;
48. Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years;
49. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults;
50. Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition;
51. Coverage for prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum; and
52. Orders, tests, screenings, and treatment by a pharmacist for health conditions or situations that include:
    a. Influenza
    b. Group A streptococcus pharyngitis
    c. SARS-COV-2;
    d. Uncomplicated urinary tract infection;
    e. Human immunodeficiency virus, limited to the provision of pre-exposure prophylaxis and post-exposure prophylaxis; and
    f. Other emerging and existing public health threats identified by the New Mexico medical board or department of health during civil or public health emergencies.

Prostate Specific Antigen Testing

Covered services include an annual digital rectal examination and prostate specific antigen tests performed to determine the level of prostate specific antigen in the blood for a *member* who is average-risk and at least 50 years of age (if high-risk of prostate cancer, eligibility starts between 40-49 years of age).

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a *covered service* (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), mammogram, ultrasound, Artery calcification testing). *Prior authorization* may be required, see your *Summary of Benefits and Coverage (SBC)* for details.

NOTE: Depending on the service performed, two bills may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

Non-participating providers should not bill you for *covered services* for any amount greater than your applicable participating cost sharing responsibilities when *balance billing protections* apply to the radiology, imaging, and other diagnostic testing services

Second Medical Opinion

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

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

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

Sleep Studies

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

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

Smoking Cessation Counseling/Program

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

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

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

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

1. Nicotine Gum
2. Nicotine Patches

3. Nicotine Lozenges
4. Nicotine oral or nasal spray
5. Nicotine inhaler
6. Bupropion
7. Varenicline

Social Determinants of Health Supplemental Benefits

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

Social determinants of health benefits and services may be offered to *members* through the "My Health Pays" wellness program and through our websites. *Members* may receive notifications about available benefits and services through emails and/or through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services.

Surgical Expense Benefits

Surgical *covered services* but not limited to charges:

1. For *surgery* in a *physician's* office, *inpatient facility*, or at an *outpatient surgical facility,* including services and supplies.
2. Made by an assistant surgeon.
3. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
4. For mastectomy and prophylactic mastectomy. Coverage for *medically necessary* surgical removal of the breast (mastectomy) is for not less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer, unless the member and the *provider* determines that a shorter period of hospital stay is appropriate.
    a. As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.
    b. Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy

5. For *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
6. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema. Benefits for *reconstructive surgery* will also include *medically necessary* health care services related to gender affirming care and the treatment for gender dysphoria. *Inpatient* stays will be no less than 48 hours for a mastectomy and no less than 24 hours for lymph node dissection unless ordered by a *physician*.
7. Bariatric *surgery* for *members* with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at risk for increased morbidity due to specific obesity related comorbid medical conditions.
8. For dental treatment in a *hospital* or *ambulatory surgical center*. Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or *surgery*, subject to *prior authorization* by us.
    a. A *member* under age eight (8) whose treating health care professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
    b. A *member* who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any dental treatment or *surgery* if not rendered in a *hospital* or *ambulatory surgical center*.
9. For accidental dental service expenses when a member suffers an *injury* that results in damage to his or her natural teeth. *Injury* to the natural teeth will not include any injury as a result of chewing.
10. 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*, or when related to genetic inborn error of metabolism. 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.
11. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
12. Cochlear implants and bone anchored hearing aids.

13. 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.
14. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current ACA preventive care requirements;
    b. An annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood for a member who is average-risk and at least 50 years of age (if high-risk of prostate cancer, eligibility starts between 40 – 49 years of age); ; and
    c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current ACA preventive care requirements.
15. For *medically necessary* oral *surgery*, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is *medically necessary* to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental *injuries*.
    d. Treatment for temporomandibular joint (TMJ) disorder, including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.

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

Telehealth Service Benefits

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

Transplant Expense Benefits

Covered Services for Transplant Service Expenses:

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

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

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

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

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

reimbursement *limitation*s.
(ambetter.westernskycommunitycare.com/resources/handbooks-forms.html)

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

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy:
2. We will pay for *member* out of pocket costs related to *transplant* service(s) for the following:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy in the United States.
    b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant *facility*, and to and from the donor's home to the transplant *facility*, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence*, a *network facility*, or in our approved non-network *facility* when there is no *network* adequacy. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant *member* and/or donor.
    f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.WesternSkyCommunityCare.com.

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

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

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.

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

Limitations on Transplant Service Expense Benefits:
In addition to the *exclusions* and *limitations* specified elsewhere in this section:

1. *Covered services* for *listed transplants* will be limited to two transplants during any 10-year period for each *member*.
2. If a designated *Center of Excellence* is not used, *covered services* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Coverage for transplants and associated care will not be denied solely on the basis of a *covered person's* physical or mental disability and we will not deny to a *covered person* with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the *policy* solely for the purpose of avoiding coverage for organ transplants and associated care.

Urgent Care Service Benefits

Urgent care services include *medically necessary services* by *participating providers* and services provided at an urgent care center including facility costs and supplies. Care that is needed after a *PCP'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 *PCP* 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 *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-617-0390 (TTY 1-877-617-0392). The 24/7 Nurse Advice Line is available 24 hours a *day*, seven *days* a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Weight Loss Programs

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

Wellness Program Benefits

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

programs may include a reward or an incentive, which you may earn by completing different activities.

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

You may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services. The Value-Added Service Benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *enrollees* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *enrollees*. The programs and benefits available at any given time are made part of this *policy* by this reference and are subject to change by us through updates available on our website or by contacting us.

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

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

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

Rewards for participating in a wellness program are available to all *members*. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward through an alternative means. *Members* should contact Member Services so they can work with you (and, if you wish, with your doctor)

to find a wellness program that offers the same reward and is right for you in light of your health.

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

1. Better understand and manage your health conditions
2. Coordinate services
3. Locate community resources

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

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric *surgery* , except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For gym memberships, exercise equipment, or meal preparation programs.
5. For non-therapeutic or illegal abortion.
6. For expenses for television, telephone, or expenses for other persons.
7. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
8. For failure to keep a scheduled appointment.
9. For stand-by availability of a *medical practitioner* when no treatment is rendered.
10. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
11. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect or *surgeries* or *medically necessary* health care services related to gender affirming care and the treatment of gender dysphoria.
12. For diagnosis or treatment of learning disabilities.
13. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
14. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

15. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
16. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
17. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
18. For hearing aids, except as expressly provided in this *policy*.
19. For *experimental or investigational* treatment(s) or *unproven services.* The fact that an *experimental or investigational* treatment or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational* treatment or *unproven service* for the treatment of that particular condition.
20. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive *days*. If travel extends beyond 90 consecutive *days*, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 *days*.
21. For services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any *deductible amount* under your employer's workers' compensation coverage. This plan does not cover any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of *injury*, timely filing of claims, and medical treatment authorization.
22. For fetal reduction *surgery*.
23. Except as specifically identified as a *covered services* under the *policy*, services or expenses for alternative treatments, including acupressure, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
24. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
25. For *prescription drugs* for any *member* who enrolls in *Medicare* Part D as of the date of his or her enrollment in *Medicare* Part D. *Prescription drug* coverage may not be reinstated at a later date.
26. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law,* care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*, except for *covered services* which have received *prior authorization*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.

27. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
28. For any non-medically necessary court ordered care for a medical/surgical or *mental health disorder*/*substance use disorder* diagnosis, unless required by state law;
29. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, we have a right of recovery for any benefits paid in excess.
30. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This *exclusion* applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with us and/ or the child possesses an active *policy* with us at the time of birth.
31. For any medicinal and recreational use of cannabis or marijuana.
32. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
33. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
34. For expenses, services, and treatments from a Naprapathic *specialist* for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
35. For expenses, services, and treatments from a Naturopathic *specialist* for treatment of prevention, self-healing and use of natural therapies.
36. For expenses, services, and treatments related to private duty nursing in an *inpatient*, outpatient or home location.
37. For expenses for services related to dry needling.
38. For the treatment of infertility, except as expressly provided in this *policy*.
39. Vehicle installations or modifications which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair

securing devices.

40. Assertive Community Treatment (ACT)

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

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

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

TERMINATION

Termination of Policy

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

1. Failure of the member or dependent member to pay the premium and other applicable charges for coverage
2. Material failure to abide by the rules and/or policies and procedures
3. Fraud or material misrepresentation affecting coverage
4. A reason for cancellation or failure to renew which the Superintendent determines is not objectionable
5. The date we decline to renew this *policy,* as stated in the Discontinuance provision;
6. The date we receive a request from you to terminate this *policy,* or any later date stated in your request;
7. The date of your death, if this *policy* is an individual plan;
8. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*; or
9. The date a *member's* eligibility for coverage under this *policy* ceases as determined by us.

We shall provide you with 30 calendar *days* advance written notice, prior to the termination of this *policy*. Notification of cancellation of enrollment must:

1. Be in writing and dated;
2. State the reason(s) for cancellation, with specific reference to the clause of the MHCP contract giving rise to the right of cancellation;
3. State that an enrollee cannot be canceled because of health status, need for health care services, race, gender, age, or sexual orientation of covered persons under enrollee's contract;
4. State that an enrollee who alleges that an enrollment has been canceled or not renewed because of the enrollee's or covered person's health status, need for health care services, race, gender, age, or sexual orientation may request review of the cancellation by the superintendent as set forth in 13.10.17 NMAC;
5. State that in the event of cancellation by either the enrollee or MHCP, except in the case of fraud or deception in the use of services or facilities of the MHCP or knowingly permitting such fraud or deception by another, the MHCP shall, within 30 calendar *days*, return to the enrollee or subscriber the pro rata portion of the money paid to the MHCP which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the MHCP; provided, however, that the superintendent may approve other reasonable reimbursement practices;
6. State the date on which the cancellation becomes effective;
7. State that receipt by the MHCP of the proper prepaid or periodic payment, including all past due amounts, after cancellation of the contract for nonpayment shall reinstate the contract as though it had never been canceled if such payment is received on or before the due date of the succeeding prepaid or periodic payment; provided, however, that the contract may specify one or more of the following methods by which the MHCP may avoid such reinstatement:

a. In the notice of cancellation, the MHCP notifies the enrollee that if payment is not received within 15 *days* of issuance of the notice of cancellation, a new application is required and the conditions under which a new contract will be issued or whether the original contract will be reinstated;
b. If such payment is received more than 15 calendar *days* after issuance of the notice of cancellation, the MHCP refunds the payment within 20 business days; or
c. If such payment is received more than 15 calendar *days* after issuance of the notice of cancellation, the MHCP issues to the enrollee, within 20 business *days* of receipt of such payment, a new contract accompanied by a written notice clearly stating the ways in which the new contract differs from the canceled contract, including any difference in benefits or coverage;

8. State that the MHCP is prohibited from increasing the amount paid by the enrollee, except after a period of at least 30 calendar *days* from either: 1) the postage paid mailing to the enrollee at the enrollee's address of record with the MHCP; or 2) actual hand delivery to the enrollee of written notice of such proposed increase; and
9. State that the MHCP is prohibited from decreasing the benefits stated in the contract in any manner, except after a period of at least 30 calendar *days* from either: 1) the postage paid mailing to the enrollee at the enrollee's address of record with the MHCP; or 2) actual hand delivery to the enrollee of written notice of such proposed change(s).

We will not cancel your coverage for non-payment of copayments if such cancellation would constitute abandonment of a member who is hospitalized and is receiving treatment for a life-threatening condition. In addition, we will not cancel a member's coverage due to a member's refusal to follow a prescribed course of treatment.

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

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

Reinstatement
If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium, by the insurer or by any agent duly authorized by the insurance company to accept such premium, without requiring in connection therewith an application for reinstatement, shall

reinstate the *policy,* provided, however, that if the insurance company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the *policy* will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 30th *day* following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application. The reinstated *policy* shall cover only loss resulting from such accidental *injury* as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 calendar *days* after such date. In all other respects the insured and insurance company shall have the same rights thereunder as they had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 calendar *days* prior to the date of reinstatement.

Discontinuance

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

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

RIGHT OF REIMBURSEMENT

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

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

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

By accepting benefits under this plan, the *member* specifically acknowledges Western Sky Community Care, Inc.’s right of subrogation. When this plan provides health care benefits for expenses incurred due to *third party* injuries, Western Sky Community Care, Inc. shall be subrogated and succeed to the right of recovery against such *third party*, or responsible party to the extent of the benefits that Western Sky Community Care, Inc. has paid. This means that Western Sky Community Care, Inc. may proceed against any party with or without the *member’s* consent.

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party* or responsible party.
4. To give Western Sky Community Care, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *Third Party* injuries provided by this plan (regardless

of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).

5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Western Sky Community Care, Inc. as reimbursement for the full cost of all benefits associated with *Third Party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
6. That we:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.
7. To take no action that prejudices our reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
8. To sign, date, and deliver to us any documents we request that protect our reimbursement rights.
9. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.
10. To reimburse us from any money received from any *third party* or responsible party, to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That we may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse us.

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

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

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

COORDINATION OF BENEFITS

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

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

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

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

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

The term "Plan" includes:

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

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

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and

under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

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

Order of Benefit Determination Rules

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

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

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

1. If the person receiving benefits is the *member* and is only covered as an *eligible dependent* under the *other plan*, this *policy* will be primary.
2. Subject to State Statues: Social Security Act of 1965, as amended makes *Medicare* secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and *day* are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
3. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    a. The plan of the parent who has custody will be primary.
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child's

health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

4. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
5. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

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

Right to Receive and Release Needed Information

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

Claims

Notice of Claim

We must receive notice of claim within 30 calendar *days* of the date the *loss* began or as soon as reasonably possible. Upon receipt of a notice of claim, we will provide you with the forms required to submit *proof of loss* within 15 calendar *days*. If we have not provided the forms within this timeframe, the claim shall be deemed to have complied with the requirements of this *policy* as to *proof of loss*. upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written *proof of loss* must be furnished to the insurer at its said office in case of claim for *loss* for which this *policy* provides any periodic payment contingent upon continuing loss within 90 calendar *days* after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 calendar *days* after the date of such *loss*. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

How to Submit a Claim

Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for *covered services*. This may happen if your provider is not contracted with us.

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

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

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

Cooperation Provision

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

1. Sign, date, and deliver to us *authorizations* to obtain any medical or other information, records or documents we deem relevant from any person or entity.
2. Obtain and furnish to us, or our representatives, any medical or other information, records or documents we deem relevant.
3. Answer, under oath or otherwise, any questions we deem relevant, which we or our representatives may ask.

4. Furnish any other information, aid or assistance that we may require, including without *limitation*, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to us, or our representative, any information, records or documents requested by us).

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

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

Time for Payment of Claims
Indemnities payable under this *policy* for any *loss* other than *loss* for which this *policy* provides any periodic payment will be paid immediately upon receipt of due written proof of such *loss*. Subject to due written *proof of loss*, all accrued indemnities for *loss* for which this *policy* provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

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

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

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

Foreign Claims Incurred for Emergency Care
Emergency services are *covered services* while traveling outside of the United States for up to a maximum of 90 consecutive *days* from the start of travel, even if enrollment occurs during the period of travel. If travel extends beyond 90 consecutive *days*, no benefit coverage is provided for medical emergencies for the entire period of travel including the first 90 *days*.

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

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

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

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

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

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

Medicaid Reimbursement
The amount provided or payable under this *policy* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives. We will pay the New Mexico Human Services Department ("HSD") any indemnity benefits payable by us on behalf of a *member* when:
1. HSD has paid or is paying benefits on behalf of the *member* under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
2. Payment for the services in question has been made by HSD to the Medicaid provider; and
3. We are notified that the *member* receives benefits under the Medicaid program and that the indemnity benefits payable by us must be paid directly to HSD (the notice may be accomplished through an attachment to the *claim* by HSD for the indemnity benefits when the *claim* is first submitted by HSD to us).

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination
Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Legal Actions
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 calendar *days* after written *proof of loss* has been furnished in accordance with the requirements of this *policy*. No such action shall be brought after the expiration of three years after the time written *proof of loss* is required to be furnished.

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

Summary of Health Insurance Grievance Procedures

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

PO Box 10341
Van Nuys, CA 91410
Member Services: 1-833-945-2029 (TTY 711)
Fax: 1-833-886-7956
Web address: Ambetter.WesternSkyCommunityCare.com
Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

Or from the OSI by calling 1-505827-4601 or toll free at 1-855-427-5674

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

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

Medical necessity: Next, if Ambetter finds that the requested service is covered by the *policy*, Ambetter determines, in consultation with a *physician*, whether a requested service is *medically necessary*. The consulting *physician* determines medical necessity either after consultation with *specialists* who are experts in the area or after application of uniform standards used by Ambetter. For example, if you have a crippling hand *injury* that could be corrected by plastic *surgery* and you are also requesting that Ambetter pay for cosmetic plastic *surgery* to give you a more attractive nose, Ambetter might certify the first request to repair your hand and deny the second, because it is not *medically necessary*.

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

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

yourself for the services.

How long does prior authorization review take?
Standard timeline prior authorization decision: The insurer must make a prior authorization decision for most benefits within 7 working days. A standard decision timeline applies to benefit IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. However, you will be responsible for paying the provider yourself for the services. 2 certification requests that are not urgent. For example, a standard benefit certification request may involve surgical care, like routine hip replacement surgery. An insurer must make an initial decision on a standard request for an exception to an insurer's step-therapy requirements or drug formulary within 24 hours for urgent care requests and 72 hours for standard care request. A step-therapy requirement means trying a less expensive drug before "stepping up" to a more expensive option. Asking for an exception to this requirement means asking to skip the less expensive drug. A drug formulary exception request means to ask for coverage of a medication not on the formulary.

What if I need services in a hurry?
Urgent care situation: An urgent care situation occurs when a decision from the insurer is needed quickly because: (1) delay would jeopardize your life or health; (2) delay would jeopardize your ability to regain maximum function; (3) the physician with knowledge of your medical condition reasonably requests an expedited decision; (4) the physician with knowledge of your medical or behavioral health condition, believes that delay would subject you to severe pain or harm that cannot be adequately managed without the requested care or treatment; or (5) the medical or behavioral health demands of your case require an expedited decision.

If you are facing an urgent care situation or your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either authorize or deny the initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an expedited decision.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency has passed. An insurance company is not allowed to require you to obtain prior authorization for emergency care.

When will I be notified that my initial request has been either certified or denied? The insurance company is required to notify you on its decision about your initial request within the initial certification period timelines listed above. If the insurance company denies your certification request, it is required to tell you about your right to an appeal.

Appeals of Denials
What types of decisions can be reviewed?
You may request a review of two different types of decisions:

Adverse Determination: An adverse determination by an insurer includes any decision to deny or

limit your coverage based on medical necessity. This medical necessity denial can happen pre-service, through a denial of a prior authorization, or post-service, when an insurance company refuses to pay a claim. If an insurance company has adversely determined that your ongoing course of treatment that has been previously covered will no longer be covered, the insurer must notify you before ending or limiting that coverage. This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate.

An adverse denial may also include a decision by the plan to retroactively end your coverage or stop offering you coverage in the future based on your eligibility for coverage. For example, an insurance company's decision to stop offering you coverage because they believe you moved out of state is an adverse determination. ***You may request an appeal of any type of an adverse determination***.

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

Review of an Adverse Determination

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

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

If you are facing an *urgent care situation* **or** Ambetter has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your *provider* may request an expedited review and Ambetter must either certify or deny the initial request quickly. Ambetter must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an expedited decision.

IMPORTANT: If you are facing an *emergency*, you should seek medical care immediately and then notify Ambetter as soon as possible. Ambetter will guide you through the claims process once the *emergency* has passed. Ambetter is not allowed to require you to obtain prior authorization for emergency care.

Appeals of Denials
What types of decisions can be appealed?
You may request appeals of two different types of decisions: Adverse determination: An adverse

determination by an insurer includes any decision to deny or limit your coverage based on medical necessity. This medical necessity denial can happen pre-service, through a denial of a prior authorization, or post-service, when an insurance company refuses to pay a claim. If an insurance company has adversely determined that your ongoing course of treatment that has been previously covered will no longer be covered, Ambetter must notify you before ending or limiting that coverage. This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. An adverse denial may also include a decision by the plan to retroactively end your coverage or stop offering you coverage in the future based on your eligibility for coverage. For example, an insurance company's decision to stop offering you coverage because they believe you moved out of state is an adverse determination. You may request an appeal of any type of an adverse determination. Administrative decision: You may also request an appeal if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling, or reimbursement for health care services; or if your coverage has been terminated.

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

Telephone: 1-833-945-2029
Address: Ambetter from Western Sky Community Care Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
FAX # : 1-833-886-7956
Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

Always contact Ambetter first about filing an appeal or grievance and specifically ask for assistance filing an appeal or grievance.

If the insurance company is non-responsive or if you have further questions about your rights, you may contact the New Mexico Office of the Superintendent of Insurance Managed Health Care Bureau consumer assistance team at:

Telephone: 1-(505) 827-4601 or toll free at 1-855-427-5674
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689,
Santa Fe, NM 87504-1689

Or
1120 Paseo de Peralta, Fourth Floor, Santa Fe, NM, 87501
FAX #: (505) 827-4253, Attn: MHCB
E-mail: mailto:mhcb.grievance@osi.nm.us

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

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

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

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

How Long a First Level Review Takes

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

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

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

1. If you ask to have your request reviewed by Ambetter's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to

consider, and ask questions of the panel members. Your health *provider* may also address the panel or send a written statement.
2. If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

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

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

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

Ambetter's internal panel must complete its review within 30 *days* following your original request for an internal review of a request for pre-certification or within 60 *days* following your original request if you have already received the services. You will be notified within 24 hours after the panel decision. If you fail to provide records or other information that Ambetter needs to complete the review, you will be given an opportunity to provide the missing items, but the review process may take much longer and you will be forced to wait for a decision.

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

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

What's an IRO and what does it do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more

professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with Ambetter or with you. The reviewer will consider all of the information that is provided by Ambetter and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

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

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

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

Review by the Superintendent of Insurance
If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI within 20 days of the IRO decision, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.
The co-hearing officers will provide a recommendation to the Superintendent within 30 *days* after the hearing is complete. The Superintendent will then issue a final order.

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

Review of an Administrative Decision

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

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

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

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

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

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

How can I request an external review?
If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 *days*** after you receive the written decision from Ambetter. You may submit the request to OSI using forms that are provided by Ambetter. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at 1-(505) 827-4601 or toll free at 1-(855) 427-5674.

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

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

Special needs and cultural and linguistic diversity
Information about the *grievance* procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations. Call the consumer assistance number on the back of your insurance card for assistance.

Reporting requirements

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

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

GENERAL PROVISIONS

Entire Policy

This *policy*, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this *policy* shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this *policy* or to waive any of its provisions.

Non-Waiver

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

Rescissions

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

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

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with State Laws

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

Personal Health Information

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

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

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

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

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

Statement of Non-Discrimination

Ambetter from Western Sky Community Care is underwritten by Western Sky Community Care, Inc., which is a Qualified Health Plan issuer in the New Mexico Health Insurance Marketplace. Western Sky Community Care, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. Ambetter.WesternSkyCommunityCare.com

If you, or someone you are helping, have questions about Ambetter from Western Sky Community Care, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-945-2029 (TTY 711). If you believe that Western Sky Community Care, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-945-2029 (TTY 711). You may also submit a grievance by phone to 1-833-945-2029 (TTY 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

Declaración de no discriminación

Ambetter from Western Sky Community Care está suscrito por Western Sky Community Care, Inc., que es un proveedor Calificado de Planes de Salud en el Mercado de Seguros de Salud de New Mexico. Western Sky Community Care, Inc. cumple con las leyes de derechos civiles Federales aplicables y no discrimina por motivos de raza, color de piel, nacionalidad de origen (incluidos un nivel de inglés limitado y la lengua materna), edad, discapacidad o sexo (incluidos el embarazo, la orientación sexual, la identidad de género o las características sexuales). Esta es una solicitud de seguro.
Ambetter.WesternSkyCommunityCare.com

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-833-945-2029 (TTY 711). Si considera que Western Sky Community Care, Inc. no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color de piel, nacionalidad de origen (incluidos un nivel de inglés limitado y la lengua materna), edad, discapacidad o sexo (incluidos el embarazo, la orientación sexual, la identidad de género o las características sexuales), comuníquese con Servicios para Miembros al 1-833-945-2029 (TTY 711). También puede presentar una queja por teléfono al 1-833-945-2029 (TTY 711). Para obtener información sobre cómo presentar una queja por discriminación directamente ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU., visite https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

If you, or someone you are helping, have questions about Ambetter from Western Sky Community Care, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact [Member Services] at [1-833-945-2029 (TTY 711)].

Spanish	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con [Servicios para Miembros] al [1-833-945-2029 (TTY 711)].
Navajo	Daa ni, doodaii la'da ni'bineesh'a dząądi, be'esdzááh na'ídíkid 'aa Ambetter from Western Sky Community Care, dóó bineesh'a góó t'oo 'adee naash'ne di Bilagaana bizaad, ni be'esdzááh la' t'áá 'áko góó bil hánish'áásh dząądi dóó bíka'ashkíd di nihí saad gi 'ádin t'áadoo bááhilinigoo dóó di léi na'alkid lahgo 'át'éego. Dąą ni, doodaii la'da ni'bineesh'a dzaadi, be'esdzááh la nish'j dóó/doodaii na'ach'aah 'ahooszoli eii biniishl'aah bil'alnaa'alwo, ni be'esdzááh la' t'aa 'ako góó baa yíltsóós 'ooljee'lahgo 'anaa'niil bika'iishyeed dóó tse'esgizii gi 'adin t'aadoo baahilinigoo dóó di léi na'alkid lahgo 'át'éego. Góó yíltsóós saad náánálahdéé' doodaii 'ooljee'lahgo 'anaa'niil tse'esgizii, t'aa shoodi deistse' ['Anishtah Tse'esgizii] gi [1-833-945-2029 (TTY 711)].
Vietnamese	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Western Sky Community Care và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận [Dịch Vụ Thành Viên] theo số [1-833-945-2029 (TTY 711)].
German	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den [Kundendienst] unter [1-833-945-2029 (TTY 711)].
Chinese	如果您，或是您正在協助的對象，有關於 Ambetter from Western Sky Community Care 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡[會員服務部]，電話是 [1-833-945-2029 (TTY 711)]。

Arabic	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Western Sky Community Care، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ [خدمات الأعضاء] على [1-833-945-2029 (TTY 711)].
Korean	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Western Sky Community Care에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 [1-833-945-2029(TTY 711)]번으로 [가입자 서비스부]에 연락해주십시오.
Tagalog	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa [Mga Serbisyo para sa Miyembro] sa [1-833-945-2029 (TTY 711)].
Japanese	ご自身やあなたが介護している他の人が、Ambetter from Western Sky Community Careについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、[1-833-945-2029 (TTY 711)]の[メンバーサービス]にご連絡ください。
French	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous-même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter [Services aux membres] au [1-833-945-2029 (TTY 711)].
Italian	Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Western Sky Community Care e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i [Servizi per i membri] al numero [1-833-945-2029 (TTY 711)].

Russian	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Western Sky Community Care, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в [отдел обслуживания участников программы страхования] по номеру [1-833-945-2029 (TTY 711)].
Hindi	अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter from Western Sky Community Care से जुड़े प्रश्न हैं और आप दोनों अंग्रेज़ी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ़्त और समय पर सहायता और जानकारी प्राप्त करने का अधिकार है. अगर आपको या किसी ऐसे व्यक्ति को जिसकी आप मदद कर रहे हैं, सुनने और/या देखने में समस्या होती है और इससे बातचीत बाधित होती है, तो आपको बिना किसी लागत के और समय पर सहायक सहायता और सेवाएं प्राप्त करने का अधिकार है. अनुवाद या सहायक सेवाएं प्राप्त करने के लिए कृपया [1-833-945-2029 (TTY 711)] पर [सदस्य सेवाएं] से संपर्क करें.
Persian	اگر شما یا فردی که دارید به او کمک می‌کنید، سؤالی درباره Ambetter from Western Sky Community Care دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می‌کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می‌کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات امدادی لطفاً با [خدمات اعضا] به شماره [1-833-945-2029 (711 TTY) تماس بگیرید.
Thai	หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care และไม่ชำนาญในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ [บริการสำหรับสมาชิก] ที่หมายเลข [1-833-945-2029 (TTY 711)]