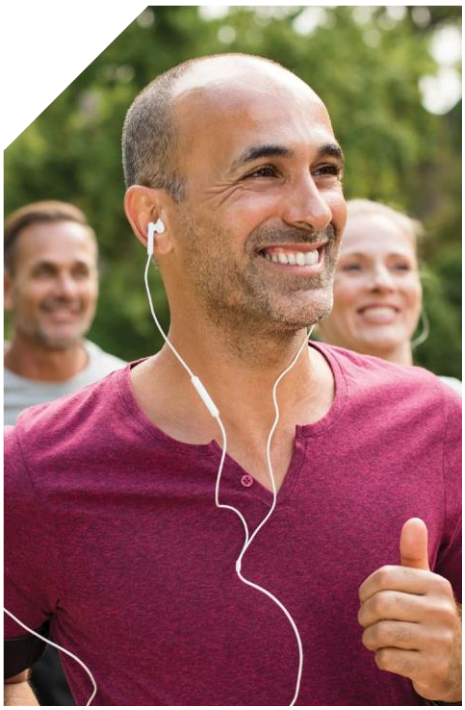
ambetter. FROM silversummit healthplan.



2025 EVIDENCE OF COVERAGE

AMBETTER

Ambetter.SilverSummitHealthplan.com

45142NV001-2025

Ambetter from SilverSummit Healthplan, Inc.

Ambetter

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

Major Medical Expense Insurance Policy

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

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, we must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy (or the new policy* you *are mapped to for the following year)* in force by timely payment of the required premiums. In most cases you will be moved to a new *policy* each year, however, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all policies issued on this form, with a new *policy* at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

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

At least 60 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 policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 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 Physician (PCP)* in order to receive care from a *specialist physician*. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization section.

TEN DAY RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within 10 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*.

Silver Summit Healthplan, Inc.

Eric R. Schmacker
Plan President and CEO

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INTRODUCTION

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

It describes:

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

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

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

How to Contact Us

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

Normal Business Hours of Operation 8:00 a.m. to 8:00 p.m. local time
Member Services: **1-866-263-8134**
TTY line: **1-855-868-4945**
Fax: **1-855-252-0568**
Emergency: **911**
24/7 Nurse Advice Line **1-866-263-8134** or for the hard of hearing TTY 1-855-868-4945

Interpreter Services

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

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

To arrange for interpretation services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITES

We are committed to:

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

If you have difficulty locating a *Primary Care Physician (PCP)*, *specialist physician*, *hospital* or other contracted provider, please contact us so we can assist you with accessing or locating a provider who contracts with us. *Physicians* within our *network* may be affiliated with different *hospitals*. Our online directory can provide you with information for the *hospitals* that are contracted with us. The online directory also lists affiliations that your provider may have with non-contracted *hospitals*. Your coverage requires you to use contracted providers with limited exceptions. Providers you may see while hospitalized may not be a contracted provider with Ambetter. It is your responsibility to ensure the provider you are seen by is a contracted provider. You can access the online directory at Ambetter.SilverSummitHealthplan.com.

You have the right to:

1. Participate with your *physician* and *medical practitioners* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians, medical practitioners*, *hospitals,* other facilities and your rights and responsibilities.
7. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* (*PCP*) about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* (*PCP*) can tell you about treatments that may or may not be covered by the *policy*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your *physician* will ask for your approval for treatment unless there is an *emergency,* and your life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.

9. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
10. See your medical records.
11. Be kept informed of *covered* and non-covered services, program changes, how to access services, *primary care physician* (*PCP*) assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 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.
12. A current list of *network providers*.
13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
14. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability or expected health or genetic status.
15. Access *medically necessary* urgent and *emergency services* 24 hours a day, seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *physician's* instructions are not followed. You should discuss all concerns about treatment with your *physician*. Your *physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
18. Select your *primary care physician* (*PCP*) within the *network*. You also have the right to change your *primary care physician* (*PCP*) or request information on *network providers* close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *primary care physician* (*PCP*).
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
22. Make advance directives for health care decisions. This includes planning treatment before you need it.
23. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing Advance directives forms. Advance directive forms are forms you can complete to protect your rights for medical care. It can help your *primary care physician* (*PCP*) and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for *yourself*. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *policy*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *primary care physician* (*PCP*). You should establish a relationship with your *physician*. You may change your *primary care physician* (*PCP*) verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *primary care physician* (*PCP*) to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any emergency room only when you think you have a medical *emergency*. For all other care, you should call your *primary care physician* (*PCP*).
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
13. Pay your monthly premiums, *deductible amounts, copayment amounts,* or *coinsurance amounts* on time.
14. Verify any provider seen, including providers seen why hospitalized, are contracted providers.
15. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *policy* within 60 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 *network providers* is available online at Ambetter.SilverSummitHealthplan.com. We have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network providers* by completing the "Find a Provider" function on our website and selecting the Ambetter *network*. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty and board certifications.

You may also contact Member Services to request information about whether a *physician*, *hospital*, or other *medical practitioner* is a *network provider*. We will respond to any such requests within 1 business day.

If you receive services from a *non-network 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 list of providers near you at no charge by calling Member Services. In order to obtain benefits, you must designate a *network primary care physician* (*PCP*) for each *member.* We can help you pick a *primary care physician* (*PCP*). We can make your choice of *primary care physician* (*PCP*) effective on the next business day.

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

Member Identification Card

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

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. Any applicable *deductibles*, and any applicable *out-of-pocket maximum amounts* 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 *member* identification card can be downloaded from Ambetter.SilverSummitHealthplan.com.

Website

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

1. Finding a *network provider,* including *hospitals* and pharmacies.

2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, makes payments, and obtain a copy of your *member* identification card.
4. Member Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our formulary or prescription drug list.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *primary care physician* (*PCP*).

Quality Improvement

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

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

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

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

Protection from Balance Billing

Under federal law, effective January 1, 2022, *non-network providers* or facilities are prohibited from *balance billing* health plan *members* for 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 *network* 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 receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation* services must be performed for three or more hours per day, five to seven days per week, while the *member* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

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

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

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a *covered service*.
3. A determination that an admission, continued stay, or other health care service does not meet our requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental or investigational, cosmetic treatment,* not *medically necessary* or inappropriate.
5. A denial of coverage based upon an eligibility determination.
6. A determination that *balance billing protections* do not apply to a service.
7. An incorrectly-calculated amount of *cost sharing* a *member* owes when *balance billing protections* apply.
8. A *rescission* of coverage determination as described in the General Provisions section of this *policy.*
9. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a *covered service*.

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

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

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

Ambetter-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.

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

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

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

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

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

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

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

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

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

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

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 *network hospital* or at a network ambulatory surgical center unless if *member* gave *notice and consent* pursuant to the federal No Surprises Act to be *balance billed* by the *non-network provider*; or
3. Air ambulance services provided to a *member* by a *non-network 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 *network 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.

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

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

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

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

Complaint means an oral expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's *authorized representative*, about an insurer or its providers with whom the insurer has a direct or indirect contract that is resolved in 24 hours of making the *complaint*.

Complications of pregnancy means:

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

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

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

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

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

Cost sharing reductions means the reduction in the amount you have to pay in *deductibles*, *copayments* and *coinsurance*. To qualify for *cost sharing reductions*, an eligible individual must enroll in a silver level plan through the Exchange. *Members* of a federally recognized American Indian tribe and/or an Alaskan Native may qualify for additional *cost sharing reductions*.

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

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

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

Custodial care includes, but is not limited to, the following:

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

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

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

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

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

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

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

Dependent member means the primary *subscriber*'s lawful *spouse*, *domestic partner* or an *eligible child*. Each *dependent member* must either be named in the enrollment application, or we must agree in writing to add them as a *dependent member*.

Domestic partner means persons who:

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

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

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

Eligible child means the child of a primary *subscriber*, if that child is less than 26 years of age. 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 the entity that you enrolled with (either the Exchange or us) if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by federal or Nevada law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* received from a *non-network provider* within Nevada, the *eligible expense* is the recognized amount as defined in *applicable law*. In Nevada, this may be based on the *non-network provider's* previous contracted fee if it was a *network provider* in the previous two years.
    b. When *balance billing protections* apply to a *covered service* received from a *non-network* provider outside of Nevada, the *eligible expense* is reimbursement as determined by us and as required by *applicable law.*
    c. For all other *covered services* received from a *non-network provider* for which any needed *authorization is received from* us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is 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 or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the 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.

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 *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 to a *hospital* as a result of an *emergency condition*, you must notify us or verify that your *physician* has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *policy*. If your provider does not contract with us, you may be financially responsible for any care we determine is not a *covered service* because it is not *medically necessary*. Care and treatment provided more than 24 hours after you have been *stabilized* is no longer considered *emergency services* under your *policy*.

Continuation of care beyond what is needed to evaluate or stabilize your condition in an *emergency* will not be a be *covered service* unless we *authorize* the continuation of care and it is *medically necessary*.

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

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

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

Experimental or investigational means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be 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 (ECF) means a *facility* that is primarily engaged in providing comprehensive post-acute hospital and inpatient rehabilitative care and is licensed by the designated government agency to provide such services. The definition of an *ECF* does not include institutions that provide only minimal, custodial, assisted living, independent living communities, extended nursing homes, residential care homes, ambulatory or part-time care services, or institutions that primarily provide for the care and treatment of *behavioral health*, or pulmonary tuberculosis.

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

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

Grievance means dissatisfaction about anything other than an *adverse benefit determination*. *Grievances* may refer to any dissatisfaction about, but are not limited to:

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

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

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

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

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

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

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

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

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

Hospital means an institution that:

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

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

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

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

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

Inpatient means that services, supplies, or treatment for 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.

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 limitations mean 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. 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 *member's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *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.

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

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

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

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 falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Minimum essential coverage means any health insurance plan that meets the Affordable Care Act (ACA) requirement(s) for health insurance coverage. Examples include, job-based plans, Health Insurance Marketplace (“Marketplace”) plans, most individual plans sold outside

of the Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Necessary medical supplies mean medical supplies that are:

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

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

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

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

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

Non-elective cesarean section means:

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

Non-network provider means a *medical practitioner, provider facility* or other provider who is NOT a *network provider*. Services received from a *non-network provider* are not covered, except for:

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

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. *Notice and consent* occurs only when each of the following conditions is met:

1. The *non-network provider* provides the *member* a written notice in the format required by *applicable law* that states the provider is a *non-network provider*, includes a good-faith estimate of the *non-network 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 *network provider*.
2. The *non-network 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 three hours before the services are furnished.
3. The *member* provides written consent to be treated by the *non-network 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-network 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-network provider* and understand they may be balance billed and subject to cost-sharing that applies to *non-network 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-network provider*.
4. The *member's* consent is provided voluntarily, obtained by the *non-network provider* in the format required by *applicable law*, and not revoked by the *member* before the services are provided.
5. The *non-network provider* provides the *member* the notice document and the consent document together, but physically separate from other documents.
6. The *non-network 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-network provider* when there is no *network 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). Otherwise, *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 *network 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-network provider* satisfies any additional requirements or prohibitions as may be imposed under *applicable state law*.

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

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

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

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

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

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

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

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

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

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

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

Prescription drug deductible amount means the amount of *covered expenses*, shown in the *Schedule of Benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *member* has met the individual *prescription drug deductible amount*, any remaining family

prescription drug deductible amount can be met with the combination of any one or more *members' eligible expenses*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service area means a geographical area, made up of counties, where we have been *authorized* by the State of Nevada to sell and market our health plans. This is where the majority of our *network providers* are located where you will receive all of your health care

services and supplies. You can receive precise *service area* boundaries from our website or Member Services.

Skilled Nursing Facility (SNF) means a facility (which meets specific regulatory certification requirements) that primarily provides *inpatient* skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a *hospital*. This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of *skilled nursing facility* care include but is not limited to intravenous injections and physical therapy.

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

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

Spouse means the person to whom you are lawfully married.

Stabilize means, with respect to a *member* who has not 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 the **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 condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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; or
6. The date a domestic partnership is established, pursuant to state law.

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

An *eligible child* born to you, or a covered family *member will* be covered from the time of birth until the 31st day after its birth, unless we have received notice from the entity that you enrolled with (either the Exchange or us). Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

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

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following placement of the child and we have received notification from the Exchange. The required premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st day following placement unless we have received both: (A) Notification of the addition of the child from the Exchange within 60 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.

Adding Other Dependent Members

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

ONGOING ELIGIBILITY

For All Members

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*;
2. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan;
3. The date of termination that the Exchange provides us upon your request of cancellation to the Exchange, or if you enrolled directly with us, the date we receive a request from you to terminate this *policy*, or any later date stated in your request;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *policy* or the date that we have not received timely premium payments in accordance with the terms of this *policy*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact at least 30 calendar days after the notice is delivered or mailed to the *member*: or
6. The date of a *member's* death.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status) or questions related to your health insurance coverage, contact the Exchange at www.nevadahealthlink.com. If you enrolled through Ambetter, you may contact Member Services.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child.* For *eligible children*, the coverage will terminate the 31st day of December the year the dependent turns 26 years of age.

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact Member Services or the Exchange at 1-800-547-2927 (TTY 711).

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

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

Open Enrollment

There will be an open enrollment period for coverage on the Exchange. The open enrollment period begins November 1, 2024, and extends through January 15, 2025. *Qualified individuals* who enroll on or before December 31, 2024, will have an *effective date* of coverage on January 1, 2025.

Special and Limited Enrollment

A *qualified individual* has 60 calendar days to report a qualifying event directly to the Exchange or by using Ambetter's *Enhanced Direct Enrollment* tool, and could be granted a 60-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 *member*'s unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, or placement for adoption of a *member* or their *spouse,* placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1;
    b. For one or more days during the 60 days preceding the date of marriage;
    c. In the case of a parent being required by an order for medical coverage for a child and the parent is eligible for coverage of *members* of the family, the parent is allowed to enroll the child in coverage without any regard to any restrictions upon enrollment periods.
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. A *member* adequately demonstrates to the Exchange that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the *member*'s decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or *member* gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
    a. The qualifying events for employees are:
        i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
        ii. Reduction in the number of hours of employment.
    b. The qualifying events for *spouses* are:
        i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
        ii. Reduction in the hours worked by the covered employee;
        iii. Covered employee's becoming entitled to Medicare;
        iv. Divorce or legal separation of the covered employee; or

v. Death of the covered employee.

c. The qualifying events for dependent children are the same as for the *spouse* with one addition:

i. Loss of dependent child status under the plan rules.

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

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

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

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

Prior Coverage

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

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

Non-Silver State Health Insurance Exchange Plan Enrollment

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

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

> After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.
>
> We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

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

> Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing

We require each policyholder to pay his or her premiums and this is communicated on your monthly billing statements. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting *third party* premiums. Consistent with CMS guidance, the following are the only acceptable third parties who may pay premiums on your behalf:

1. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations, or urban Indian organizations;
3. State and federal government programs;

4. Family *members*;
5. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan; or
6. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the *calendar year*.

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

Misstatement of Age

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

Change or Misstatement of Residence

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

Misstatement of Tobacco or Nicotine Use

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

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

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

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

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

Pursuant to the federal No Surprises Act, *emergency services* received from a *non-network provider* are *covered services* without *prior authorization*.

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

1. At least 15 days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any *inpatient* admission including emergent *inpatient* admissions.
5. At least 15 days prior to the start of *home health care* except those *members* needing *home health care* after *hospital* discharge.

After *prior authorization* has been received, we will notify you and your provider if the request has been *approved* as follows:

1. For urgent concurrent reviews within 24 hours (one calendar day) of receipt of the request.
2. For urgent *pre-service* reviews, within 72 hours (three calendar days) of receipt of request.
3. For non-urgent *pre-service* reviews within 15 calendar days of receipt of the request.
4. For *post-service* or retrospective reviews, within 30 calendar days of receipt of the request.

In situations where additional information is needed to make a decision, these timeframes may be extended in accordance with *applicable law*.

You do not need to obtain *prior authorization* from us or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a *medical practitioner* in our *network* who specializes in obstetrics or gynecology. The *medical practitioner*, however, may be required to comply with certain procedures, including obtaining *prior authorization* for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating *medical practitioners* who specialize in obstetrics or gynecology, contact Member Services.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

Failure to comply with the *prior authorization* requirements will result in benefits being reduced or not covered.

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

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

Prior Authorization Does Not Guarantee Benefits

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

Denied Prior Authorization

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

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

Except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network providers*. If a situation

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

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

The *deductible amount* means the amount of *covered services* that must be paid to a provider 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 *Schedule of Benefits* for more details.

Copayments

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

Coinsurance Percentage

A *coinsurance amount* is your share of the cost of a service. *Members* may be required to pay a provider a *coinsurance amount* in addition to any applicable *deductible amount(s)* due for a *covered service* or supply. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount.*

Maximum Out-of-Pocket

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

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*; and
2. A determination of *eligible expenses*.
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information in your *Schedule of Benefits*.

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

Non-Network Liability and Balance Billing

If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what we agreed to pay and the full billed amount 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*.

Health Savings Account (HSA)

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

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

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

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

THE TERMS OF THIS EVIDENCE OF COVERAGE ARE CONFINED TO THE BENEFITS PROVIDED HEREIN AND DO NOT ENCOMPASS ANY INDIVIDIUAL HSA FEE ARRANGEMENTS, ACCOUNT MAINTENANCE OR CONTRIBUTION REQUIREMENTS, APPLICATION PROCEDURES, TERMS, CONDITIONS, WARRANTIES OR LIMITATIONS THERETO, GRIEVANCES OR CIVIL DISPUTES WITH ANY HSA CUSTODIAN OR TRUSTEE.

ACCESS TO CARE

Primary Care Physician (PCP)

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

1. Family practitioners
2. General practitioners
3. Internal medicine
4. Nurse practitioners*
5. Physician assistants
6. Pediatricians (for children)

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

You may obtain a list of *network PCPs* at our website and using the "Find a Provider" function or by contacting Member Services.

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

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. You may be required to obtain a referral from your *PCP* in order to receive care from a *specialist physician*. You do not need a referral from your *network PCP* for *emergency care* services, mental or *behavioral health* services or services from an obstetrician/gynecologist. You may seek services from a *network* obstetrician/gynecologist, a *behavioral health* or *substance use disorder* provider directly without a written *referral*.

Changing Your Primary Care Physician (PCP)

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

Contacting Your Primary Care Physician (PCP)

To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need to cancel or change your appointment, call 24 hours in advance. If you need help, call Member Services 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 1-866-263-8134 (TTY 1-855-868-4945). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Network Availability

Your *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A *network* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving or as soon as possible. You may have the opportunity to disenroll from coverage under this *policy* and enroll in a different health plan with a *network* in that area. **Note**: Services received from *non-network providers* are generally not *covered services* under this *policy*, except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*. If you receive *covered services* from *non-network providers* that are not subject to *balance billing protections*, benefits will be calculated in accordance with the terms of this *policy* for *non-network providers.*

Coverage Under Other Policy Provisions

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

Emergency Services Outside of Service Area

We cover *emergency 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. You do not need *prior authorization* for *emergency services*.

Hospital Based Providers

When receiving care at a *network hospital* it is possible that some hospital-based providers may not be *network 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-network provider* in excess of the *eligible expense* will not apply to your *deductible* amount or *maximum out-of-pocket amount*.

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 the *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 us 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 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 end of the pregnancy for *continuing care patients* who are pregnant and undergoing a course of treatment for the *pregnancy*, and 120 days after the notice described in (1) is provided for all other c*ontinuing care patients*; or
    b. The date on which such *member* is no longer a *continuing care patient* with respect to the provider.

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.

Preferred Partnership

As innovative technologies and solutions are established in market under expedited research and development, we may elect to offer, at our discretion, new services or preferred partnerships designed to improve access to care and enhance *care management*. Ambetter

will provide access to *third party* services at preferred or discounted rates. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

MAJOR MEDICAL EXPENSE BENEFITS

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

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

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

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

Acquired Brain Injury Services

Benefits for *eligible expenses* incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition 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.

Treatment for an *acquired brain injury* may be provided at a hospital, an acute or post-*acute rehabilitation* hospital, a skilled nursing facility or an approved facility where *covered services* are provided. Treatment goals for services may include the maintenance of functioning, or the prevention or slowing of further deterioration. *Custodial care* and long-term nursing care are not *covered services* under this *policy*.

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

1. Has incurred an *acquired brain injury*;
2. Has been unresponsive to treatment; and
3. Is medically stable; and

4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered with the expectation that with the provision of these services and support, the person can return to a community-based setting, rather than reside in a facility setting.

Ambulance Service Benefits

Air Ambulance Service Benefits

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

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.

Limitations: 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.
5. Non-emergency air transportation (for example, commercial flights).

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

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

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

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

Autism Spectrum Disorder Benefits

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. *Behavioral health* services 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*.

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the same day by different providers, a separate *copayment* and/or *coinsurance* will apply to each provider.

BRCA Screening Coverage

Screening, genetic counseling and testing for BRCA genetic mutations is a covered service for adult female members with a family history of breast, ovarian, tubal or peritoneal cancer or an ancestry associated with a harmful mutation in the BRCA gene, or who meet any other criteria under which the United States Preventive Services Task Force has recommended screening for a risk of such a mutation, as determined by the member's PCP, who have not already undergone such screening.

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.

Chiropractic Services

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

Clinical Trial Coverage

Clinical trial coverage includes routine patient care costs incurred as the result of an approved phase I, II, III, or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition or phase II, III or IV for treatment of chronic fatigue syndrome. Coverage will include routine patient care costs incurred for:

1. drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition;
2. reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial; and
3. all items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
    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.

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

1. 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
2. The insured is enrolled in the clinical trial. This section shall not apply to insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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*.

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.

Covered services include, but are not limited to:

1. Examinations including podiatric examinations;
2. Routine foot care such as trimming of nails and corns;
3. Laboratory and radiological diagnostic testing;
4. Self-management equipment, supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles;
5. Orthotics and diabetic shoes;
6. Urinary protein/microalbumin and lipid profiles;

7. Educational health and nutritional counseling for self-management, eye examinations, prescription medication; and retinopathy examination screenings, as *medically necessary*.

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

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

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. You may receive hemodialysis in a dialysis facility or peritoneal dialysis in your home from a *network provider*.

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 of an artificial kidney machine.

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

Disposable Medical Supplies

Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to, bandages and wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes and applicators. The supplies are subject to the *member's* medical *deductible amount*, *copayment amount* and/or *coinsurance amount*.

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

The supplies, equipment, and appliances described below are *covered services* under this benefit. All types of durable medical equipment and supplies are subject to *prior authorization* as outlined in this *policy*. Please see your *Schedule of Benefits* for benefit levels or additional limits. 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*; and
3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

Durable Medical Equipment

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

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for I.V. fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. 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/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

Durable medical equipment and supplies are subject to *prior authorization* as outlined in this *policy*. See your *Schedule of Benefits* for benefit levels or additional limits.

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

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

Exclusions:
Non-covered services and supplies include, but are not limited to:
1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive Care Expense Benefits provision).
6. Med-injectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

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

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

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

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

Orthotic devices may be replaced once per year per *member* when *medically necessary* in the *member's* situation. However, additional replacements will be allowed for *members* when *medically necessary* or for any *member* when an appliance is damaged and cannot be repaired.

Exclusions:
Non-covered services and supplies include, but are not limited to:
1. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
2. Garter belts and other supplies not specifically made and fitted (except as specified under the Medical Supplies provision above).

Prosthetics
Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. *Covered services* include purchase, fitting, needed adjustment, repairs, and replacements of *prosthetic devices* and supplies if:
1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

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

Covered services and supplies may include, but are not limited to:
1. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or

glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Cochlear implant and bone anchored hearing aids.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per *calendar year*) when purchased through a *network provider*.

Exclusions:
Non-covered prosthetic appliances include, but are not limited to:

1. Dentures, replacing teeth, or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
4. Wigs (except as described above) when purchased through a *non-network provider*.
5. Penile prosthesis when *medical necessity* criteria are not met or is strictly a cosmetic procedure.

Emergency 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-network provider* may not balance bill you for the difference between our *allowed amount* and their *billed amount*.

Family Planning and Contraception

Family planning/contraception benefits are covered under preventive care, without *cost sharing* when provided by a *network 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 the Health Resources and Services Administration (HRSA):

1. The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including:
    a. sterilization *surgery* for women
    b. implantable rods
    c. copper intrauterine devices
    d. intrauterine devices with progestin (all durations and doses)
    e. injectable contraceptives,
    f. oral contraceptives (combined pill)
    g. oral contraceptives (progestin only)

h. oral contraceptives (extended or continuous use)
i. the contraceptive patch
j. vaginal contraceptive rings
k. diaphragms
l. contraceptive sponges
m. cervical caps
n. condoms
o. spermicides
p. emergency contraception (levonorgestrel) and
q. emergency contraception (ulipristal acetate).

2. 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).
3. 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).
4. Instruction in fertility awareness-based methods, including lactation amenorrhea.

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

Covered Preventive Services for Women and Pregnant Women include, but is not limited to:

1. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
2. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
3. Domestic and interpersonal violence screening and counseling for all *members*;
4. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
5. Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists, or its successor organization;
6. Screening for blood pressure abnormalities;
7. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
8. Cervical cancer screening for sexually active *members*;
9. Screening for depression;
10. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
11. Human Papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
12. *Tobacco* or *nicotine use* screening and interventions for all *members*, and expanded counseling for pregnant *tobacco* users;
13. All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, or its successor organization; and
14. Well-woman visits to obtain recommended preventive services.

Gender Affirming Services

Medically necessary gender affirming services, including, but not limited to, psychotherapy, pre-surgical and post-surgical hormone therapy, and surgical services (e.g., such as genital surgery and mastectomy), for the treatment of gender dysphoria are covered.

Services not *medically necessary* for the treatment of gender dysphoria are not covered. Gender affirming surgical services must be performed by a qualified provider in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

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

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

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

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

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

Home Health Care Service Expense Benefits

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

1. *Home health aide services*; only if provided in conjunction with skilled registered nurse or licensed practical nursing services.

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

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

Limitations:
Home health care services and benefits are subject to *prior authorization* requirements as outlined in this *policy*. See your *Schedule of Benefits* for benefit levels or additional limits for expenses related to *home health aide services*. *Home health care* services not in conjunction with a registered or licensed practical nurse and home health aide are not covered.

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

Hospice Care Service Expense Benefits

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

Respite care is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a covered *member* under Hospice Care. Respite days that are applied toward the *member's cost share* obligations are considered *covered services* and shall apply against any maximum benefit limit for these services. See your *Schedule of Benefits* for coverage limits. Respite services, provided as part of *hospice* care, are limited to 5 *inpatient* days/outpatient visits per 90 days.

Benefits for *hospice inpatient*, home and *outpatient* care is subject to *prior authorization* as outlined in this *policy*. See your *Schedule of Benefits* for coverage limits.

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

7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling.*

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

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

Human Immunodeficiency Virus Preventative Coverage

Drugs approved by the United States Food and Drug Administration for preventing the acquisition of Human Immunodeficiency Virus (HIV) and necessary laboratory testing for HIV drug therapy are *covered services* under this *policy*, including when provided by an in-network pharmacist.

Human Papillomavirus (HPV)

Covered services include immunization vaccines (doses, recommended ages and recommended populations vary) for the Human Papillomavirus vaccine and Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older.

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 six hours or more per day
   c. Ventilator management required at least every four 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.

Lymphedema Benefit

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

Mammography

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

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

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

Diagnostic mammograms are more in-depth than screenings and do not fall under preventive care coverage and are also covered without *cost share*. Diagnostic mammograms are typically for individuals with suspicious results on a screening mammogram or after some sign of breast cancer is detected.

Maternity Care

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

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

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

Duty to Cooperate

If a *member* requires maternity services, even if acting as a *surrogate*, those maternity services shall be covered. *Members* who are a *surrogate/gestational carrier* at the time of enrollment or *members* who agree to a *surrogacy/gestational carrier arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy/gestational carrier arrangement*, send us written notice of the *surrogacy/gestational carrier arrangement* to Silver Summit Health Plan at Member Services, 2500 North Buffalo Drive, Suite 250, Las Vegas, NV 89128.

Note: This provision does not amend this *policy* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates/gestational carriers* and children born from *surrogates/gestational carriers*. Please reference General Non-Covered Services and Exclusions section as limitations may exist.

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

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

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered 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 this *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered services* for childbirth.

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. Laboratory testing that is necessary for therapy that uses preventative HIV drugs as required by state law
e. Gastrointestinal laboratory procedures
f. Pulmonary function tests
g. Genetic testing
h. 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 elective sterilization procedures (e.g., vasectomies). **Note:** No *cost-share* applies, except for HSA-compatible plans.
5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
6. 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 provision of this *policy*.
7. 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.
8. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
9. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to*:*
    a. 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.
    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 *network* 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. Skin grafts.
    e. Prosthetic tissue replacement, including joint replacements.
    f. Implantable prosthetic lenses, in connection with cataracts.
15. Any type of hormone replacement therapy which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.
16. For x-rays, Magnetic Resonance Imaging (MRI), Computed 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*.
17. For *medically necessary telehealth services. Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in person.
18. Limited diagnostic and therapeutic infertility services determined to be *medically necessary* and requires *prior authorization*. *Covered services* do not include those services specifically excluded herein, but do include limited:
    a. Laboratory studies;
    b. Diagnostic procedures; and
    c. Artificial insemination services, up to six (6) cycles per *member* per lifetime.
19. *Prior authorized medically necessary* bariatric *surgery*, and complications from bariatric *surgery*, for extreme obesity under the following conditions:
    a. Have a body mass index (BMI) of greater than 40kg/m2; or
    b. Have a BMI greater than 35kg/m2 with significant co-morbidities; and
    c. Can provide documented evidence that dietary attempts at weight control are ineffective; and
    d. Must be at least 18 years of age.
20. For surgery or services related to cochlear implants and bone-anchored hearing aids.
21. For *medically necessary* services for complications arising from medical and surgical conditions.

22. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy. Please see Habilitation, Rehabilitation and Extended Care Facility Expense Benefits provisions of this *policy*.
23. For *medically necessary* nutritional counseling, *prior authorization* may be required.
24. 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.
25. For *medically necessary* footcare treatment that may require surgery; prior authorization may be required.
26. For dermatology services which are limited to the following: *medically necessary* minor surgery, tests and office visits provided by a dermatologist who is a *network provider*.
27. For *medically necessary* biofeedback services.
28. For therapeutic abortion performed to save the life or health of the *member* or as the result of incest or rape.
29. 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.
30. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only.
31. 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.
32. *For medically necessary* care and treatment of medically diagnosed congenital defects and birth abnormalities in newborns.
33. For *medically necessary* allergy testing and treatment including allergy injections and serum.

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

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

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

Coverage is also provided for:

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

Medical Foods

We cover medical foods and formulas for:

1. outpatient total parenteral nutritional therapy
2. nutritional counseling
3. outpatient elemental formulas for malabsorption
4. dietary formula (when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism).

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.

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

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

Medical Service Benefit

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

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

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

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

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.

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

1. Referrals to a *specialist physician* for evaluation and diagnosis of refractive error, including presbyopia.
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

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

If you need *mental health disorder* or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* provider *network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network behavioral health* providers by accessing our "Find a Doctor" tool at Ambetter.SilverSummitHealthplan.com or by calling Member Services. *Deductible amounts*, *copayment amounts,* or *coinsurance amounts* and treatment limits for covered *mental health disorder* and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

Our *behavioral health* utilization management staff utilizes Change Healthcare InterQual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered *inpatient* and outpatient *mental health disorder* and/or *substance use disorder* services are as follows:

Inpatient

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. *Inpatient rehabilitation*;
4. Crisis stabilization;

5. *Residential treatment facility* for *mental health disorder* and *substance use disorders*; and
6. Electroconvulsive therapy (ECT).

Outpatient

1. Partial hospitalization program (PHP);
2. Intensive *outpatient* program (IOP);
3. Mental health day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for *mental health disorder* and s*ubstance use disorders*;
6. Individual and group therapy, and family counseling for *mental health disorder* and *substance use disorders*;
7. Medication assisted treatment- combines *behavioral health* therapy and medications to treat *substance use disorders.* **Note**: Pharmacists may prescribe and administer medication assisted treatment for use of opioid use disorder;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis*;
11. Telemedicine (individual/family therapy; medication monitoring; assessment and evaluation);
12. Electroconvulsive Therapy (ECT); and
13. *Transcranial Magnetic Stimulation (TMS).*

Expenses for these services are covered if *medically necessary* and may be subject to *prior authorization*. However, we will not require *prior authorization* for emergent *inpatient* withdrawal management services or emergent *inpatient* treatment services. Please see the *Schedule of Benefits* 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*. Please call Member Services to be referred to a care manager for an assessment.

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *member*.
3. For four mastectomy bras per year if the *member* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
6. For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*.
7. For the cost of one pair of hearing aids per *member*. See the *Schedule of Benefits* for benefit levels or additional limits.

Pediatric Routine Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological examination
    a. Refraction
    b. Dilation
2. Standard frames
3. Prescription lenses
    a. Single
    b. Bifocal
    c. Trifocal, or
    d. Lenticular
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. Contact lenses and contact lens fitting fee (in lieu of glasses)
6. Low vision evaluation/aids

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

Services not covered:

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

Prescription Drug Expense Benefits

We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases.

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

1. A *prescription drug.*
2. Prescribed, oral anticancer medication. Self-administered oral cancer drugs are capped at $100 per 30-day supply.

3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.
4. Preventative HIV drugs and oral contraceptives, covered on the formulary, will be covered, regardless if a prescription is required or not, provided that appropriate pharmacy dispensing procedures are followed by a *network* pharmacy.
5. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *Standard Reference Compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
6. If the governor of Nevada issues a state of emergency or issues a declaration of disaster, we will waive any restriction of the time within which a *member* may refill a covered prescription drug to the extent permitted by *applicable law*, provided the *member*:
    a. Has not exceeded the number of refills authorized by the prescribing *physician*;
    b. Resides in the area for which the emergency or disaster has been declared; and
    c. Requests the refill not later than 30 days after the issuance of the declaration of a state of emergency or disaster, whichever is later.
7. We will *authorize* payment for, and may apply a *copayment, coinsurance,* or *deductible* to, a supply of a covered prescription drug for up to 30 days for a *member* who requests a refill pursuant to number 6.

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

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

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

Extended Days' Supply
Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills (up to 90 days) of select maintenance medications are available exclusively through select pharmacies. For more information, please consult our website.

In-network pharmacy: Up to 30-day supply of maintenance medications and non-maintenance medications
Retail: Maintenance medications with days' supply of 84-90 days
Mail Order: Maintenance medications with days' supply of 31-90 days

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

Note: The formulary is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated and may be subject to change. Drugs may be added or removed, or additional requirements may be added in order to approve continued usage of a specified drug.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter formulary or prescription drug list or for more information about our pharmacy program, visit Ambetter.SilverSummitHealthplan.com (under “For Member”, “Drug Coverage”) or call Member Services.

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

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

If you decide to have your prescription filled at a *network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at Ambetter.SilverSummitHealthplan.com on the “Find a Doctor” page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your *member* identification card.

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

Mail Order Pharmacy
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.*

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

Extended Days' Supply
Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills (up to 90 days) of select maintenance medications are available exclusively through select pharmacies. For more information, please consult our website.

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs*, unless specifically listed on the formulary.
3. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary.
8. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *experimental or investigational* drugs.
9. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
10. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by any retail or mail order or a pharmacy 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 may be subject to the discounted *cost sharing*. Mail orders less than 90-days are subject to the standard *cost sharing* amount.
11. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
12. Foreign prescription medications, except those associated with an *emergency* medical condition while you are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
13. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.

14. For medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. Drugs or dosage amounts determined by Ambetter's Pharmacy and Therapeutics Committee to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
20. For any drug related to surrogate *pregnancy* for non-covered members acting as a surrogate.
21. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 days' supply of medication on hand, excluding early refills of topical ophthalmic products.
24. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
25. For immunization agents otherwise not required by the Affordable Care Act.

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

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

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

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

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

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

Prescription Drug Synchronization
Under Nevada law, you have the right to request synchronization of your medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example, if you fill medication A on the 5th of each month and your provider prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help you adjust your fill dates for medication B and synchronize the fill dates with medication A. We will adjust *copays* to reflect shorter or longer coverage. If you would like to exercise this right, please call our Member Services.

Prescription Drug Exception Process
Non-formulary exception requests
Standard exception request
A *member*, a *member's authorized representative* or a *member's* prescribing *physician* may request a standard review for a non-formulary drug. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Step therapy exception requests
Standard exception request
A *member*, a *member's authorized representative* or a *member's* prescribing *physician* may request a standard review for exception to the step therapy protocol. The request can be made in writing or via telephone. Within 2 business days of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination.

Exception requests for stage 3 or 4 cancer treatment
Members with a diagnosis of stage 3 or 4 cancer, or the treating *physician* of such a *member*, are eligible under this *policy* to apply for an exemption to the step therapy protocol that would otherwise be required. Exception requests can be submitted using regular prior authorization procedures.

Requests for exemptions must include the clinical rationale for the exemption and any relevant medical information and accompanying supporting documentation including the medical history

or other health records of the *member* establishing that the *member* has tried other drugs included in the pharmacological class of drugs for which the exemption is requested without success, or taken the requested drug for a clinically appropriate amount of time to establish stability in relation to the cancer and the guidelines of the prescribing practitioner. Each application shall be reviewed by at least one physician, registered nurse, or pharmacist. We will disclose the qualifications of each reviewer of the application to the applicant.

Requests for exemption are available online at Ambetter.silversummithealthplan.com/provider-resources/manuals-and-forms.html.

How to request an exemption:
To request non-formulary exemption, exemption to step-therapy protocol or cancer diagnosis drug use exemption the provider can follow regular prior authorization procedure.

Upon receiving the application, we will determine whether the application is complete or request additional information or documentation necessary to complete the application, within 72 hours for non-formulary drugs and 2 business days for step therapy protocol exemption. If we request additional information or documentation, we will make a determination within 72 hours for non-formulary drugs and 2 business days for step therapy protocol exemption, of receiving the requested information or documentation.

If, in the opinion of the attending *physician*, a step therapy protocol may seriously jeopardize the life or health of the *member*, we will make the determination as expeditiously as necessary to avoid serious jeopardy to the life or health of the *member*.

Applications for exemptions will be granted for *members* for whom: any treatment otherwise required under the step therapy or any drug in the same pharmacological class or having the same mechanism of action as the drug for which the exemption is requested has not been effective at treating the cancer or symptom of the *member*; or delay of effective treatment would have severe or irreversible consequences for the *member* and the treatment otherwise required under step therapy is not reasonably expected to be effective based on the physical or mental characteristics of the *member* and the known characteristics of the treatment; or each treatment otherwise required under the step therapy is contraindicated for the *member* or has caused, or is likely based on peer-reviewed clinical evidence, to cause an adverse reaction or other physical harm to the *member*, or has prevented or is likely to prevent the *member* from performing the responsibilities of his or her occupation or engaging in the activities of daily living; or the condition of the *member* is stable while being treated with the prescription drug for which the exemption is being requested and the *member* has previously received approval for coverage of that drug; or any other condition for which such an exemption is required by regulation is met.

If we approve an application for an exemption from the step therapy protocol, we will provide coverage for the prescription drug to which the exemption applies for as long as is necessary to treat the *member* for the cancer or symptom. We may initially limit coverage to the prescription drug to a one-week supply. If the attending *physician* determines that after one week the drug is effective at treating the cancer or symptom for which it was prescribed, we will continue to cover the drug for as long as is necessary to treat the cancer or symptom. We may conduct a review once a quarter to determine, in accordance with available medical evidence, whether the drug remains necessary to treat the *member* for the cancer or symptom. Upon such review, we will provide a report of the review to the *member*.

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

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

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

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA, to the extent the care is not illegal under *applicable law*.

Preventive care benefits obtained from a *network provider* are covered without *member cost share* (i.e., covered in full without *deductible amount*, *coinsurance amount* or *copayment amount*). For current information regarding available preventive care benefits, please access the federal government's website at

www.healthcare.gov/coverage/preventive-care-benefits/.

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

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

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

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.SilverSummitHealthplan.com To request a paper copy, please contact Member Services for assistance.

Prostate Specific Antigen Testing

Covered services include 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 at 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 and ultrasound). *Prior authorization* may be required; see your *Schedule of Benefits* for details.

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

Non-network 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 *injury* or *illness* exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

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

Sleep Studies

Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required. **Note:** A sleep study can be performed either at home or in a facility.

Transplant Expense Benefits

Covered services for Transplant Service Expenses:
Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with this *policy*. *Prior authorization* must be obtained through a *Center of Excellence* before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery.* Transplant services must meet medical criteria as set by Medical Management *policy*.

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

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

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.

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

Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations Ambetter.SilverSummitHealthplan.com/resources/handbooks-forms.html.

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

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence:*
2. We will pay for the following services, subject to the maximum identified in the *Schedule of Benefits*:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany to and from the *Center of Excellence* in the United States.
    b. When the *member,* donor and/or companion(s)is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective homes to the transplant facility, plus miles traveled:
        i. Between the transplant facility and local lodging; and.
        ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.
    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 companion(s) 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 in the United States. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant

reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within six months of the date of service in order to be reimbursed.

Please refer to the Member Resources page for *member* reimbursement transplant travel forms and information at Ambetter.SilverSummitHealthplan.com.

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
6. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight.
7. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
8. For any transplant services and/or travel related expenses for *member* or donor, when performed outside of the United States.
9. The following ancillary items listed below, will not be subject to *member* reimbursement under this *policy*:
    a. Alcohol/*tobacco*
    b. Car, trailer, or truck rental (unless pre-approved by Case Management)
    c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking (unless pre-approved by Case Management)
    e. Storage rental units
    f. Temporary housing incurring rent/mortgage payments
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s)
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    i. Moving violation tickets or parking tickets
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    k. Any services related to pet care, boarding, lodging, food, and/or travel expenses
    l. Expenses for persons other than the transplant recipient, donor or their respective companion
    m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend, or otherwise have free lodging
    n. Any expense not supported by a receipt
    o. Upgrades to first class travel (air, bus, and train)
    p. Personal care items (e.g., shampoo, deodorant, clothes)

q. 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
r. Souvenirs (e.g., t-shirts, sweatshirts, toys)
s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
t. Any fuel costs/charging station fees for any vehicle (but note that mileage is reimbursable)
u. Any tips, concierge, club level floors, and gratuities
v. Salon, barber, and spa services
w. Insurance premiums
x. *Cost share amounts* owed to the transplant surgeon or facility or other provider.

Urgent Care Service Benefits

Urgent care services include *medically necessary* services by *network 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 1-866-263-8134 (TTY 1-855-868-4945). 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.

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *policy*, we may offer wellness programs and other services to *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *members*. The programs and services are available to you as part of this *policy* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at Ambetter.SilverSummitHealthplan.com or by contacting Member Services.

The Ambetter Health preventive care and wellness program includes offerings for health check-ups, screenings for common conditions and vaccinations. Rewards may be available through the “My Health Pays” program for completing specific activities that promote healthy behaviors and address *social determinants of health*. *Members* may receive communications and outreach about this program.

We also offer general wellness, health improvement and care management programs that may include a reward or incentive that you may earn for completing different wellness-related activities.

If you have a medical condition that may prohibit you from participating in a wellness program, 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 can access other services in connection with this *policy*, such as the “Ambetter Health Perks” program, which offers discounts on a wide range of activities, services, goods, financial tools, memberships, out-of-pocket prescription expenses, over-the-counter (OTC) health products, and health- and wellness-related services addressing s*ocial determinants of health* and healthy lifestyle. *Members* are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. *Members* may also have access to a zero-interest line of credit through the Ambetter Health Perks program for paying their *deductibles, copayments*, and *coinsurance* on *covered services*, with several repayment options to fit their needs. The Ambetter Health Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors, if you choose to participate.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, except as specifically covered in the Major Medical Expense Benefits section of this *policy*.
4. For weight loss programs, gym memberships, exercise equipment or meal preparation programs.
5. For the reversal of elective sterilization procedures.
6. For non-therapeutic or illegal abortion.
7. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described under the Major Medical Expense Benefits section.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.
12. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Major Medical Expense Benefits section.
13. 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.
14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits provision under the Major Medical Expense Benefits section.

15. For the following *mental health disorder* services:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that would otherwise be covered under this *policy*;
    d. Testing for ability, aptitude, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
16. For Assertive Community Services (ACT)
17. Services which are custodial or residential in nature.
18. Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
19. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
21. For expenses, services, and treatment related to private duty nursing in an inpatient location.
22. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
23. 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*.
24. For hearing aids, except as expressly provided in this *policy*.
25. 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.
26. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
27. For fetal reduction *surgery*.
28. Except as specifically identified as a *covered service* under the *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, 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.
29. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if

the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

30. 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.
31. 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.
32. 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*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
33. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
34. Biofeedback.
35. *Surrogacy/gestational carrier arrangement.*
    The following health care services, including supplies and medication to a non-covered *member* serving as a *surrogate/gestational carrier* pursuant to a *surrogacy/gestational carrier arrangement* with a *member* are excluded. This exclusion applies to all health care services, supplies and medication to the non-covered *surrogate/gestational carrier* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate/gestational carrier* following childbirth);
    d. *Mental health disorder* services related to the *surrogacy/gestational carrier arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage relating to a *surrogacy/gestational carrier arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy/gestational carrier arrangement*;
    h. Preimplantation genetic diagnoses relating to a *surrogacy/gestational carrier arrangement*;
    i. Any complications of the *surrogate/gestational carrier* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to the *surrogacy/gestational carrier arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate/gestational carrier* as a result of a *surrogacy/gestational carrier arrangement* are also excluded. This exclusion shall not apply, where a *member* possessing an active *policy* with us is the intended parent of the child as defined under NRS 126.590

and pursuant to NRS 126.720 and/or the child possesses an active *policy* with us at the time of birth. **Note:** We will not deny, limit or seek reimbursement for maternity care because you are acting as a *gestational carrier*.

36. For expenses for services related to dry needling.
37. For any medicinal and recreational use of cannabis or marijuana.
38. Immunizations that are not *medically necessary*. This includes those used for travel and occupational.
39. For expenses, services and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
40. 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.
41. For expenses, services, and treatments from a naturopathic specialist for treatment of prevention, self-healing and use of natural therapies.
42. For all health care services obtained at an *urgent care center* that is a *non-network provider*.
43. For treatment of infertility, except as expressly provided in this *policy*.
44. 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.

TERMINATION

Termination of Policy

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

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

Refund upon Cancellation

We will refund any premium paid and not earned due to *policy* termination. You may cancel the *policy* at any time by providing written notice to the entity in which you enrolled. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If you cancel, we shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 20 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

Reinstatement

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

Discontinuance

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

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

RIGHT OF REIMBURSEMENT

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

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

By accepting benefits under this plan, the *member* also specifically acknowledges SilverSummit Healthplan, Inc.'s right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party injuries* and the *member* or the *member's* representative has recovered any amounts from any other valid coverage as defined in NRS 689A.230.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. To give SilverSummit Healthplan, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any other valid coverage as defined in NRS 689A.230.
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation from other valid coverage as defined in NRS 689A.230.
6. 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.
7. To sign, date, and deliver to us any documents we request that protect our reimbursement rights.
8. To reimburse us from any money received from any other valid coverage as defined in NRS 689A.230.
9. 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 other valid coverage as defined in NRS 689A.230.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit. In the event you or your representative fail to cooperate with SilverSummit Healthplan, Inc., you shall

be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by SilverSummit Healthplan, Inc. in obtaining repayment.

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

COORDINATION OF BENEFITS

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

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

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

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

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

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Plan includes *hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
3. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
4. Plan whose benefits are by law excess to any private benefits coverage.
5. Individual plans.

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

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

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

Order of Benefit Determination Rules

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

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other valid coverage*.
2. If the *other valid coverage* does not contain a coordination of benefits provision that is consistent with this provision, then it is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the 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 *member* 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 valid coverage*, this *policy* will be primary.
2. Subject to federal laws: Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other valid coverage* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other valid coverage* will determine which plan is primary.
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 stepparent’s plan, the plan of the parent with custody will pay first, the stepparent’s plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child’s health care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the decree.
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 valid coverage* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

5. If the person receiving services is the *member* and is covered under a separate stand-alone dental benefit plan, that stand-alone dental benefit plan shall be primary for services provided by an oral and maxillofacial surgeon.
6. 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 valid coverages*. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and *other valid coverages* covering the person claiming benefits. We need not tell or get the consent of any person to do this.

CLAIMS

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

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

How to Submit a Claim
Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for *covered services*. This 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 less any *deductible*, *copayment* or *cost sharing* that is your financial responsibility.

To request reimbursement for a *covered service*, you need a copy of the detailed claim from your provider. You also need to submit a copy of the *member* reimbursement claim form posted at Ambetter.SilverSummitHealthplan.com under “Member Resources.” Send all the documentation to us at the following address:

Ambetter from SilverSummit Healthplan
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

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

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

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no

further action will be taken by us unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

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

Time for Payment of Claims

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

Payment of Claims

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

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

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

Foreign Claims Incurred for Emergency Care

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

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

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

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 and Autopsy

We shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at our expense and as often as we may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

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

No Third Party Beneficiaries

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

APPEAL AND GRIEVANCE PROCEDURES

Internal Procedures

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

Call Member Services

Please contact Member Services if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

Appeals

Applicability/Eligibility

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

An eligible appellant is:

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

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

Appeals Process

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

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

You or your *authorized representative* may file an *appeal* by calling Member Services or in writing by mailing or faxing your *appeal* to:

Claimants should submit all documentation to us at:
Ambetter from SilverSummit Healthplan
ATTN: Appeals & Grievances Department
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128
Fax Number: 1-855-742-0125

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

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

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

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

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

The time period may be extended for an additional 14 calendar days, making the maximum time for the entire *appeal* process 44 calendar days. If an extension is necessary, we will provide you or your authorized representative, if applicable, written notification of the following within the first 30 calendar days:

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

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

1. The claimant will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will have 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days,

the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The claimant will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the claimant 10 calendar days to respond to the new medical rationale before making a determination.

Right to Appear

The claimant who filed the *appeal*, or the claimant's *authorized representative*, has the right to appear in person before the grievance panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *appeal*.

1. Written notification must be sent to the claimant indicating the time and place of the grievance panel meeting at least seven calendar days before the meeting; and
2. Reasonable accommodations must be provided to allow the claimant, or the claimant's *authorized representative*, to participate in the grievance panel.

Grievance Panel

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

The grievance panel will include:

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

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

Expedited Appeal

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

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

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

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

Written Appeal Response

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

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

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *appeal*;
3. The signature of one voting *member* of the panel; and
4. A written description of position titles of panel *members* involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant 's claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
    e. If the *adverse benefit determination* is based on a medical necessity or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
    f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
    g. The date of service;
    h. The health care provider's name;
    i. The claim amount;
    j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
    k. The health plan's denial code with corresponding meaning;
    l. A description of any standard used, if any, in denying the claim;
    m. A description of the external review procedures, if applicable;
    n. The right to bring a civil action under state or federal law;
    o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
    p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
    q. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Grievances

Applicability/Eligibility

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

An eligible grievant is:

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

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

Grievance Process

Basic elements of a *grievance* include:

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

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

You or your *authorized representative* may file a *grievance* by calling Member Services or in writing by mailing or faxing your *grievance* to:

Ambetter from SilverSummit Healthplan
Attn: Grievances Department
P.O. Box 10341
Van Nuys, CA 91410
Phone: 1-866-263-8134
Fax Number: 1-833-886-7956

If filing a written *grievance*, please include:

1. Your first and last name
2. Your *member* identification number
3. Your address and telephone number
4. Details surrounding your concern
5. Any supporting documentation

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

Resolution Timeframes
Grievances regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire *grievance* process 44 calendar days. If an extension is necessary, we will provide the claimant and the claimant's *authorized representative*, if applicable, written notification of the following within the first 30 calendar days:

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

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

Complaints received from the State Insurance Department

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

External Review

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

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

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

Applicability/Eligibility
The g*rievance* procedures apply to:

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

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

1. The internal *appeal* process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*; and
    b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received *emergency services*, but has not been discharged from a facility; and
3. Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested, and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.

External review is available for *grievances* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a *covered service*; or the determination that a treatment is *experimental or investigational*, as determined by an external reviewer;
2. A determination of whether *balance billing protections* apply and the *member cost-sharing* that applies for services subject to *balance billing protections*; or
3. *Rescissions* of coverage.

External Review Process

1. We have five (5) business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *member* at the time the item or service was requested;
    b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity *experimental or investigational*, medical judgment, or *rescission*;
    c. The claimant has exhausted the internal process; and

d. The claimant has provided all of the information required to process an external review.

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

Binding Arbitration

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

if a party to the arbitration is also involved in another action or proceeding with a *third party* arising out of the same matter.

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

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

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

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

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

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

The arbitrator is required to follow applicable state or federal law and must be conducted pursuant to the rules for commercial arbitration established by the AAA. The arbitrator may interpret this *policy*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be

available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings. Judgment upon the award rendered by the Arbitrator(s) may be entered by any court having jurisdiction thereof.

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

Please note that any requirements in this "Binding Arbitration" section will not apply to the extent they are not permitted under *applicable law*, but all requirements that are permitted by *applicable law* will apply.

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

The Office of Consumer Health Assistance is also available to assist consumers understand their rights and responsibilities under their health insurance plans. You can contact them at 555 East Washington Avenue, Suite 4800 Las Vegas, NV 89101 or by calling 1-(888) 333-1597. You may also email them at CHA@govcha.nv.gov.

Appeal and Grievance Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Expedited Grievance	180 Calendar Days	N/A	72 Hours	N/A
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	N/A
Standard Post-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
External Review	4 Months	N/A	15 Calendar Days	N/A
Expedited External Review	4 Months	N/A	72 Hours	N/A

GENERAL PROVISIONS

Entire Policy
This *policy,* including the endorsements and the attached papers, if any, constitutes the entire *policy* of insurance*.* No change in this *policy* shall be valid until approved by an executive officer of the insurer and unless such approval is 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
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

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

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

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

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes your medical

information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit Ambetter.SilverSummitHealthplan.com/privacy-practices.html or call Member Services.

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

Language

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

English:	If you, or someone you are helping, have questions about Ambetter from SilverSummit Healthplan, 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 1-866-263-8134 (TTY 1-855-868-4945).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from SilverSummit Healthplan 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 1-866-263-8134 (TTY 1-855-868-4945).
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from SilverSummit Healthplan, 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 pannikin 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 1-866-263-8134 (TTY 1-855-868-4945).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from SilverSummit Healthplan 方面的問題，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 1-866-263-8134 (TTY 1-855-868-4945)。
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from SilverSummit Healthplan에 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 1-866-263-8134 (TTY 1-855-868-4945)번으로 가입자 서비스부에 연락해주십시오.
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from SilverSummit Healthplan 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 1-866-263-8134 (TTY 1-855-868-4945).
Amharic:	እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ስለ Ambetter from SilverSummit Healthplan ጥያቄ ካለዎት እና እንግሊዝኛ ብቁ ካልሆኑ፣ ያለምንም ወጪ እና በጊዜው በቋንቋዎ እርዳታ እና መረጃ የማግኘት መብት አልዎት። እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ግንኙነትን የሚያደናቅፍ የመስማት እና/ወይም የእይታ ችግር ካልዎት፣ አጋዥ እርዳታዎችን እና አገልግሎቶችን ያለ ምንም ወጪ እና በጊዜው የመቀበል መብት አልዎት። የትርጉም ወይም ረዳት አገልግሎቶችን ለማግኘት እባክዎ በ 1-866-263-8134 (TTY 1-855-868-4945) የአባል አገልግሎቶች ን ያናግሩ።

Thai:	หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from SilverSummit Healthplan และไม่ชำนาญในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-866-263-8134 (TTY 1-855-868-4945)
Japanese:	ご自身やあなたが介護している他の人が、Ambetter from SilverSummit Healthplan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、1-866-263-8134 (TTY 1-855-868-4945)のメンバーサービスにご連絡ください。
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from SilverSummit Healthplan، 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 1-866-263-8134 (TTY 1-855-868-4945).
Russian:	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from SilverSummit Healthplan, 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 1-866-263-8134 (TTY 1-855-868-4945).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from SilverSummit Healthplan 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 1-866-263-8134 (TTY 1-855-868-4945).
Persian:	اگر شما یا فردی که دارید به او کمک می‌کنید، سؤالی درباره Ambetter from SilverSummit Healthplan 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 1-866-263-8134 (TTY 1-855-868-4945) تماس بگیرید.
Samoan:	Afai e te le lelei i le Igilisi ma o oe po'o se tasi o lo'o e fesoasoani i ai o lo'o i ai ni fa'afitauli e uiga i le Ambetter from SilverSummit Healthplan, o lo'o ia te oe le ai e maua fua ai ma vave fesoasoani ma fa'amatalaga i lau lava gagana. E iai lau ai tatau e maua fua ma vave fesoasoani fesoasoani ma au'aunaga pe afai o oe po'o se tasi o lo'o e fesoasoani i ai o lo'o i ai se fa'aletonu i le va'ai po'o le fa'alogo e faigata ai feso'ota'iga. Ina ia maua auaunaga faaliliu upu poo tulaga tau aafiaga tumau i le soifua, faamolemole, faafesoota'i le 'Auauanga a le au paia le 1-866-263-8134 (TTY 1-855-868-4945).

German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from SilverSummit Healthplan hat 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 1-866-263-8134 (TTY 1-855-868-4945).
Ilocano:	No sika, wenno ti maysa a tultulungam, ket addaan kadagiti saludsod maipapan iti Ambetter from SilverSummit Healthplan, ken saan a nalaing iti Ingles, adda karbengam a makagun od iti tulong ken impormasion iti pagsasaom nga awan ti gastos ken iti naintiempuan a wagas. No sika, wenno ti maysa a tultulungam, ket addaan iti problema iti panagdengngeg ken/wenno panagkita a manglapped iti komunikasion, adda karbengam nga umawat kadagiti kanayonan a tulong ken serbisio para ti disabilidad nga awan ti gastos ken iti naintiempuan a wagas. Tapno makaawat kadagiti serbisio ti panagipatarus wenno para ti disabilidad, maidawat a kontakem ti Serbisio iti Miembro iti 1-866-263-8134 (TTY 1-855-868-4945).

AMB24-NV-C-00014
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