There are two different versions of this Evidence of Coverage. The first Evidence of Coverage is for the On-Exchange plans. The second Evidence of Coverage is for the Mirrored Off-Exchange plans.

The 2021 Evidence of Coverage, beginning on Page 2, covers the On-Exchange plans.

The 2021 Evidence of Coverage, beginning on Page 105, covers the Mirrored Off-Exchange plans.

ambetter. FROM western sky community care

2021 Evidence of Coverage

Ambetter.WesternSkyCommunityCare.com

Member Services Department: 1-833-945-2029 (TDD/TTY: 711)
Log on to: Ambetter.WesternSkyCommunityCare.com

Ambetter from Western Sky Community Care, Inc.

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

Major Medical Expense Insurance Policy

In this *policy,* the terms *"you"*, *"your",* or *"yours"* will refer to the *member* or any *dependents* named on the *Summary of Benefits and Coverage (SBC)*. The terms *"we," "our,"* or *"us"* will refer to Western Sky Community Care, Inc.

AGREEMENT AND CONSIDERATION

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

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

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

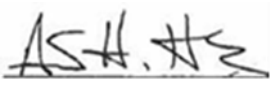
At least 60 *days'* notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *member's* health.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

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

TEN DAY RIGHT TO RETURN POLICY

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

Western Sky Community Care, Inc.



Antonio H. Hernandez]
CEO and Plan President

TABLES OF CONTENTS

Introduction

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

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

This *policy*, the *Summary of Benefits and Coverage (SBC)*, the application as submitted to the Health Insurance Marketplace, 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. Since many of the provisions are interrelated, *you* should read the entire *policy* to get a full understanding of *your* coverage. Many words used in the *policy* have special meanings: these words are *italicized* and are defined for *you* in the Definitions section. This *policy* also contains *exclusions*, so please be sure to read this *policy* carefully.

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

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. MST
Member Services **1-833-945-2029**
TDD/TTY line **711**
Fax **1-833-751-0895**
Emergency **911**
24/7 Nurse Advice Line **1-855-604-1303** or for the hearing impaired (TDD/TTY 711)

Interpreter Services
Ambetter from Western Sky Community Care, Inc. 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. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

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

Member Rights and Responsibilities

We are committed to:

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

If *you* have difficulty locating a primary care provider, *specialist*, *hospital* or other contracted provider please contact us so that we can assist *you* with access or in locating a contracted Ambetter provider. Ambetter physicians may be affiliated with different hospitals. Our online directory can provide *you* with information on the Ambetter contracted hospitals. The online directory also lists affiliations that your provider may have with non-contracted hospitals. Your Ambetter coverage requires *you* to use contracted providers with limited *exceptions*.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Have services available and accessible when *medically necessary*.
5. Have access to urgent and emergency care services 24 hours per day, seven days per week, and for other health care services as defined by the *policy*.
6. Be treated with courtesy and consideration, and with respect for the covered person's dignity and need for privacy.
7. Be provided with information concerning *our* policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
8. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
9. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
10. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care practitioner* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care practitioner* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information

can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.

11. Make recommendations regarding *member's* rights, responsibilities, and policies.
12. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
13. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
14. See *your medical records*.
15. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care practitioner* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 *days* before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
16. Receive prompt notification of termination or changes in benefits, services or provider network.
17. A current list of *participating providers*.
18. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
19. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion.
20. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
21. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care practitioner's* instructions are not followed. *You* should discuss all concerns about treatment with *your primary care practitioner*. *Your primary care practitioner* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
22. A complete explanation of why care is denied.
23. An opportunity to appeal the denial decision to *us*, the right to a secondary appeal, and the right to request the superintendent's assistance.
24. Select *your primary care practitioner* within the *network*. *You* also have the right to change *your primary care practitioner* or request information on *participating providers* close to *your* home or work.
25. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your primary care practitioner*.
26. An interpreter when *you* do not speak or understand the language of the area.
27. A *second opinion* by a *network physician*, at no cost to *you*, if *you* believe your *participating provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
28. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
29. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care practitioner* 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 *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *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* ID 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 practitioner*. *You* should establish a relationship with *your physician*. *You* may change *your primary care practitioner* verbally or in writing by contacting *our* Member Services Department.
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. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. 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 practitioner* 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.
12. Follow all health benefit plan guidelines, provisions, policies, and procedures.
13. Use any *emergency* room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care practitioner*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 *days* from the date of the event.

Provider Directory
A listing of *participating providers* is available online at Ambetter.WesternSkyCommunityCare.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our participating providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter Network. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-833-945-2029 (TDD/TTY: 711). In order to obtain benefits, *you* must designate a *network primary care practitioner* for each *member. We* can also help *you* pick a *primary care practitioner* (*PCP*). *We* can make *your* choice of *primary care practitioner* effective on the next *business day*.

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

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

The ID card will show *your* name, member ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-833-945-2029 (TDD/TTY: 711). *We* will send *you* another card.

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

1. Finding a *participating provider*.
2. Locate other *providers* (e.g., *hospitals* and pharmacies)
3. *Our* programs and services, including programs to help *you* get and stay healthy.
4. A secure portal for *you* to check the status of *your* claims, make payments, and obtain a copy of *your* Member ID card.
5. Member Rights and Responsibilities.
6. Notice of Privacy Practices.
7. Current events and news.
8. *Our* Formulary or Preferred Drug List.
9. *Deductible* and *copayment* accumulators.
10. Selecting a *Primary Care Provider*.

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 Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement

We are committed to providing quality healthcare 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 Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *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 healthcare and specific diseases.
3. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee which includes *participating providers* to help *us* develop and monitor *our* program activities.
5. Investigating any *member* concerns regarding care received.

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

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 healthcare and services *you* are receiving.

Definitions

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

Wherever used in this *policy*:

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

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

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

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

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

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

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

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

Authorization or ***Authorized*** (also "*Prior Authorization*" or "*Approval*") means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or provider group.

Autism spectrum disorder means *autism spectrum disorder* as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases (ICD-10).

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

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

Complications of pregnancy means:

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

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *policy*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

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

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

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

Cost sharing reductions means *reductions* in *cost sharing* for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

Covered person means a subscriber, policyholder, or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

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

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

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

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

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

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

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

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

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

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

Dental services 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 *your* lawful *spouse* or an *eligible child*.

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 *covered person*, if that child is less than 26 years of age. As used in this definition, "child" means:

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

It is *your* responsibility to notify the Health Insurance Marketplace 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 service expense means a *covered service expense* as determined below.

1. For *participating providers*: When a *covered service* is received from a *participating provider*, the *eligible service expense* is the contracted fee with that *provider*.
2. For *nonparticipating providers*:

a. When a *covered service* is received from a *nonparticipating provider* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the greatest of the following:
    i. the amount that would be paid under *Medicare*,
    ii. the amount for the *covered service* calculated using the same method *we* generally use to determine payments for out-of-network services, or
    iii. the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts.

Please note: *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.

b. When a *covered service* is received from a *nonparticipating provider* as *approved* or *authorized* by *us* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*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 service expense* is the greater of (1) the amount that would be paid under *Medicare*, or (2) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.
c. When a *covered service* is received from a *nonparticipating provider* because the service or supply is not available from any *participating provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept 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 service expense* is the greater of (1) the amount that would be paid under *Medicare*, or (2) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.
d. Please note: In other circumstances, you may be balance billed if you knowingly choose to receive non-emergency care from a *nonparticipating provider*.

Emergency* (Medical, Behavioral Health, and Substance Use) *Services means covered *inpatient* and *outpatient services* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an *emergency* medical/behavioral health condition. An *emergency* medical/behavioral health medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain)

that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious harm to self or others due to an alcohol or drug use emergency; *Injury* to self or bodily harm to others; or with respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another *hospital* before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

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

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

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

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

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

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

Facility means an entity providing health care service, including:

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

Generally accepted standards of medical practice are 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 any dissatisfaction with 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 including 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.

Habilitation or ***habilitation services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or outpatient settings.

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

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

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

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

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

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

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily *medical record* on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing *generally accepted standards of medical practice* for the *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 refers to services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by an Ambetter physician. Ambetter works with certified hospice programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of terminally ill *members* and their *immediate family*.

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

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

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

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

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

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

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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

Loss of minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a

fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an *HMO*, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual);
3. In the case of coverage offered through an *HMO*, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual;
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance* percentage of *covered expenses*, as shown in the *Summary of Benefits and Coverage (SBC)*. After the *maximum out-of-pocket amount* is met for an individual, Western Sky Community Care, Inc. pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Summary of Benefits and Coverage (SBC)*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any *covered persons' eligible service expenses*. A *covered person's maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket amount*.

If *you* are a covered *member* in a family of two or more *members*, *you* will satisfy *your maximum out-of-pocket* when:

1. *You* satisfy *your* individual *maximum out-of-pocket*; or
2. *Your* family satisfies the family *maximum out-of-pocket amount* for the *calendar year*.

If *you* satisfy *your* individual *maximum out-of-pocket*, *you* will not pay any more *cost sharing* for the remainder of the *calendar year*, but any other eligible *members* in *your* family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the *calendar year*.

The dental out-of-pocket maximum limits do not apply to the satisfaction of the *maximum out-of-pocket* per *calendar year* as shown in the *Summary of Benefits and Coverage (SBC)*.

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

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

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

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

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

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

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

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

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

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from *Medicare* for treating *Medicare*-eligible individuals.

Member means an individual covered by the health plan including an enrollee, subscriber, or policyholder.

Mental disorder means a behavioral, emotional, or cognitive disorder that is listed in the most recent edition of the International Classification of Diseases.

Necessary medical supplies means 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 the group or groups of *participating providers* who provide health care services under a network plan.

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

Non-elective caesarean section means:

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

Nonparticipating provider means a *provider* who is not a *participating provider* as defined. Also known as an out-of-*network provider* or non-contracted *provider*.

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

component of a *prosthetic device*.

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

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

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

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

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

Period of extended loss means a period of consecutive days:

1. Beginning with the first *day* on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive *day* for which he or she is not a *hospital inpatient.*

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

Policy when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Post-service claim means a claim submitted to a health insurance carrier by or on behalf of a *covered person* after health care services have been provided to the *covered person*.

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

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

Note: *Practitioner of the healing arts* could be a *primary care practitioner (PCP)*

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

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

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

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

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

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

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

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

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

Prosthetic device means an artificial leg or arm.

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

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

Qualified health plan or ***QHP*** means a major medical plan that has been reviewed and deemed by the superintendent to provide *essential health benefits*, follow established limits on cost-sharing, provide "minimum essential coverage" and meet the other requirements of the Affordable Care Act.

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* from which an improvement in physiological function could reasonably be expected, when ordered by a *member's* primary care practitioner or treating health care professional and performed for the correction of functional disorders resulting from accidental *injury* or from congenital defects or disease.

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

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

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

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

Rehabilitation licensed practitioner means, but is not limited to, a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be

licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

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.

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

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

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

Specialist physician means a *physician* who is not a *primary care practitioner.*

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

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

Spouse means *your* lawful wife or husband.

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance use disorders* are those listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases (ICD-10).

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

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

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

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

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

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

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent Member Coverage

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

The *effective date* for *your* initial *dependent members,* if any, is shown on the *Summary of Benefits and Coverage (SBC)*. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for a Newborn Child

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

Covered services for a newborn child include:

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

Additional premium will be required to continue coverage beyond the 31st *day* after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Health Insurance Marketplace 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 Health Insurance Marketplace within 60 *days* of the birth of the child, the *policy* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage

of the child will terminate on the 31st *day* after its birth, unless *we* have received notice by the Health Insurance Marketplace 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 when *we* have received notification from the Marketplace. 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 Marketplace within 60 *days* of the birth or placement and (B) any additional premium required for the addition of the child within 90 *days* of the date of *placement.*

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

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

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

Court Order to Provide Child Coverage
When *you* are required by a court order or an administrative order to provide coverage for an *eligible child* *we* shall:
1. Permit the eligible parent to enroll, under the family coverage under this *policy*, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
2. If the eligible parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency

administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

3. Not disenroll or eliminate coverage of the child unless *we* are provided satisfactory written evidence that:
    a. The court or administrative order is no longer in effect.

Adding Other Dependent Members

If *you* are enrolled in an on-exchange policy and apply in writing 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 ID cards for the added *dependent*.

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 date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
3. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
4. The date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request, or if *you* are enrolled through the Marketplace, the date of termination that the Marketplace provides *us* upon *your* request of cancellation to the Marketplace;
5. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this contract or the date that *we* have not received timely premium payments in accordance with the terms of this contract;
6. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g. the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract); or
7. The date of a *member's* death.

For Dependent Members

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

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 handicap or physical handicap 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 Health Insurance Marketplace. The open enrollment period begins November 1, 2020 and extends through December 15, 2020. *Qualified individuals* who enroll on or before December 15, 2020 will have an *effective date* of coverage on January 1, 2021.

Special and Limited Enrollment

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

1. A *qualified individual* or *dependent loses minimum essential coverage,* non-*calendar year* group or individual health insurance coverage, *pregnancy*-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;

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

The Health Insurance Marketplace 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 *advanced 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 *advanced premium tax credits* and cost-sharing *reduction* payments until the first of the next month.

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 ten (10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing

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

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

4. Family members.

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 subscription charges remain due. If an HRA is offered, employer payments would be acceptable and exempt from the limitation.

Similarly, if we determine payment was made for *deductibles* or *cost sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a third party premium payment that may not be counted towards your *deductible* or maximum-out-of-pocket costs.

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

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Health Insurance Marketplace 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 section on Special Enrollment Periods for more information.

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

Prior Authorization

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

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

Prior Authorization Required

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

For services or supplies that require *prior authorization*, as shown on the *Summary of Benefits and Coverage (SBC)*, *you* must obtain *authorization* from *us* before *you* or *your dependent member:*

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

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

Prior Authorization requests must be received by phone/efax/ Provider portal as follows:

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

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

1. For immediate request situations, within 1 *business day*, when the lack of treatment may result in an emergency room visit or *emergency* admission.
2. For urgent concurrent reviews within 24 hours of receipt of the request.
3. For urgent *pre-service* reviews, within 72 hours from date of receipt of request.
4. For non-urgent *pre-service* reviews within 5 *days*, but no longer than 15 *days*, of receipt of the request.
5. For post-service or retrospective reviews, within 30 calendar *days* of receipt of the request.

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

Failure to Obtain Prior Authorization
Failure to comply with the *prior authorization* requirements may result in denial of payment.

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

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

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

Services Requiring Prior Authorization
1. Adult Accidental Dental
2. Bariatric Surgery Inpatient
3. Bone Anchored Hearing Aids
4. Cardiac Rehabilitation
5. Cochlear Implants
6. Corrective Footwear Orthotics Shoes Inserts
7. Delin Inpatient Services Maternity Care
8. Diabetic Footwear
9. Diabetic Footwear Orthotics
10. Durable Medical Equipment
11. Hearing Aid Supplies Batteries
12. Home Healthcare
13. Imaging
14. Infertility Diagnostic Testing
15. Inherited Metabolic Disorder
16. Inpatient Facility Admission
17. Inpatient Mental Health
18. Inpatient Rehabilitation
19. Inpatient Substance Use
20. Mastectomy Bra
21. Neurodevelopmental Therapy

22. Neurological Rehabilitation
23. Outpatient Rehabilitation
24. Outpatient Substance Use
25. Outpatient Surgery Doctor
26. Outpatient Surgery Facility
27. Private Duty Nursing
28. Respite Care
29. Rx Preferred Drug
30. Rx Specialty Drug
31. Rx Specialty Mail Drug
32. Specialist Visit
33. Skilled Nursing Facility
34. Sleep Study
35. TMJ Treatment
36. Transplant
37. Wigs

Cost Sharing Features

Cost Sharing Features

We will pay benefits for *covered services* as described in the *Summary of Benefits of Coverage (SBC)* and the Covered Services sections of this Contract. All benefits *we* pay will be subject to all conditions, *limitations*, and *cost sharing* features of this Contract. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, *you* may need to pay a *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 Summary of Benefits of Coverage (SBC)*.

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

Copayments

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

Coinsurance Percentage

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

Deductible

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

Refer to your Summary of Benefits and Coverage (SBC) for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*; and
2. A determination of *eligible service expenses*.

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

Note: The bill *you* receive for services or supplies from a *nonparticipating provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing percentage*, *you* are responsible for the difference between the *eligible service expense* and the amount the *nonparticipating provider* bills *you* for the services or supplies. Any amount *you* are obligated to pay to the *nonparticipating provider* in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

Access to Care

Primary Care Provider

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

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

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

Any female *member* age 13 or older may designate an OB/GYN as a *network primary care practitioner*. *You* may obtain a list of *network primary care practitioners* at *our* website and using the "Find a Provider" function or by contacting *our* Member Services department.

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

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

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

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

Contacting Your Primary Care Practitioner
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. At every appointment, make sure *you* bring *your member* ID card and a photo ID.

Should *you* need care outside of *your* PCP's office hours, *you* should call *your* PCP's office for information on receiving after hours care in your area. If *you* have an urgent medical problem or question or cannot reach *your* PCP during normal office hours, call *our* 24/7 nurse advice line at 1-877-687-1180 (TTY/TDD 1-877-941-9231). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

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

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *participating providers*. *You* will be notified of any increase in premium.

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

Non-Emergency Services
If you are traveling outside of the New Mexico service area *you* may be able to access providers in another state. *You* can locate Ambetter providers outside of New Mexico by searching the relevant state in our directory at ProviderSearch.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* ID card for further information.

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

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

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

Sometimes, *our* medical director and/or medical management staff will identify technological advances that could benefit *our* members. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether *we* should change any of *our* benefits to include the new technology.
If the CPC does not review a request for coverage of new technology, *our* Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request a future meeting.

Major Medical Expense Benefits

Ambulance Service Benefits

Covered service expenses will include *ambulance services* for local transportation:

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

Benefits for air *ambulance services* are limited to:

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

Exclusions:
No benefits will be paid for:

1. Expenses incurred for *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. *Ambulance services* provided for a *member's* comfort or convenience.
5. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Autism Spectrum Disorder Benefits

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

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

- evaluation and assessment services;
- *applied behavior analysis*;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy;
- *habilitation* services with a diagnosis of *autism spectrum disorder*; or

- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Coronavirus; COVID-19 Public Health Emergency

Coverage includes testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency as long as the public health emergency remains in effect, either declared by the state of New Mexico or federal government.
There is no *member cost sharing* requirements for testing and/or delivery of healthcare services that are related to COVID-19.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, diabetes education when received from a *medical practitioner*/*provider* who is approved to provide diabetes education; exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
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.

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices

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

- The equipment, supply, or appliance is a *covered service*;
- The continued use of the item is *medically necessary*; and
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is

not reasonable justification).

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

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

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

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

Exclusions:

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

1. Air conditioners.
2. Ice bags/coldpack pump.

3. Raised toilet seats.
4. Rental of equipment if the *member* is in a *facility* that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

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

Medical and surgical supplies

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

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

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

Exclusions:

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

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

Orthotic devices

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

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.

7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

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

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

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

<u>Prosthetics</u>
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 Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or *injury*; the first pair of

contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
7. Restoration prosthesis (composite facial prosthesis).
8. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

*Exclusion*s:
Non-covered prosthetic appliances include, but are not limited to:

1. Dentures, replacing teeth, or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
4. Wigs (except as described above following cancer treatment).
5. Penile prosthesis in adults suffering impotency resulting from disease or *injury*.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 *days* of a *hospital* stay of at least 3 consecutive *days* and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* 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 U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient rehabilitative physical therapy, occupational therapy, and speech therapy.

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

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

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

Home Health Care Service Expense Benefits

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

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

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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.

Limitations:
See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits for expenses related to *home health aide services*.

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

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a hospice care program. *Covered services* and supplies include:

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

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

Benefits for *hospice inpatient*, home and outpatient care are available.
Exclusions and *Limitations*:
Any *exclusion* or *limitation* contained in the *policy* regarding:

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

Hospital Benefits

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

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

Emergency Room Services

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

Medical Expense Benefits

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

1. Made by a *physician* or *specialist* for professional services, including *surgery*.
2. For the professional services of a *medical practitioner*.
3. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
4. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included) which includes but are not limited to:
    1. Sleep disorder studies in home or facility which may require *prior authorization*;
    2. Bone density studies;
    3. Clinical laboratory tests;
    4. Gastrointestinal lab procedures;
    5. Pulmonary function tests.
5. For chemotherapy and radiation therapy or treatment.
6. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.

7. For the cost and administration of an anesthetic.
8. For oxygen and its administration.
9. For *medically necessary chiropractic care* and acupuncture treatment on an outpatient basis only. Coverage limited to 20 visits/calendar year, unless it is habilitative and rehabilitative in nature. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
10. Family Planning for certain professional *provider* contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
11. *Medically necessary services* made by a *physician* in an *urgent care center*, including *facility* costs and supplies.
12. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
13. Allergy services including testing and sera.
14. Allergy serum extracts.
15. *Medically necessary telehealth* services subject to the same clinical and *utilization review* criteria, plan requirements, *limitations* and *cost sharing* as the same health care services when delivered to an insured in person.
16. For *medically necessary* genetic blood tests.
17. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
18. For *medically necessary* biofeedback services.
19. For *medically necessary* allergy treatment.
20. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
21. *Telehealth* services are covered for medical outpatient services and mental health and substance use disorder outpatient services.

Surgical Expense Benefits

Surgical *covered services* but not limited to charges:

1. For *surgery* in a *physician's* office, inpatient facility, or at an *outpatient surgical facility,* including services and supplies.
2. Made by an assistant surgeon.
3. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
4. For *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
5. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
6. Bariatric surgery for *members* with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at risk for increased morbidity due to specific obesity related comorbid medical conditions.
7. Accidental Dental.

8. 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.

Mental Health and Substance Use Disorder Benefits

Our behavioral health and substance use vendor oversees the delivery and oversight of covered behavioral health and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our* behavioral health and substance use vendor's *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *You* can search for in-network Behavioral Health *providers* by using *our* Find a Provider tool at Ambetter.WesternSkyCommunityCare.com or by calling Member Services at 1-833-945-2029 (TDD/TTY 711). *Deductible amounts*, *copayment,* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most recent edition of the International Classification of Diseases (ICD-10).

When making coverage determinations, *our* behavioral health and substance use vendor utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and substance use vendor utilizes Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance abuse* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

1. Individual and group mental health evaluation and treatment;
2. *Outpatient services* for the purpose of monitoring drug therapy;
3. Medication management services;
4. Outpatient detoxification programs;
5. Psychological and Neuropsychological testing and assessment;
6. Outpatient *rehabilitation* treatment;
7. *Applied Behavioral Analysis*;
8. Telemedicine;
9. Partial Hospitalization Program (PHP);
10. Intensive Outpatient Program (IOP);
11. Mental health day treatment;
12. Electroconvulsive Therapy (ECT);
13. *Transcranial Magnetic Stimulation (TMS)*

In addition, Integrated Care Management is available for all of *your* healthcare needs, including behavioral health and substance use. Please call 1-866-263-8134 (TDD/TTY 1-855-868-4945) to be referred to a care manager for an assessment.

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

Other Dental Services

Anesthesia and *hospital* charges for dental care are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient *ambulatory surgical center* for the following:

1. *Members* exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
2. *Members* for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
3. *Eligible child* who is extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral dental morbidity;
4. *Members* with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
5. Other procedures for which hospitalization or general anesthesia in a *hospital* or *ambulatory surgical center* is *medically necessary*.

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. This coverage does not apply to treatment for temporomandibular joint disorders(TMJ).

Other *dental services* shall be limited to the following conditions when deemed *medically necessary*:

6. Accidental *injury* to sound natural teeth, jaw bones, or surrounding tissues;
7. Correction of a non-dental physiological condition which has resulted in a severe functional impairment; or
8. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *covered person*.
3. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
6. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
7. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery.
8. For the cost of one hearing aid per *eligible child* under the age of 18 (or under the age of 21 if still attending high school) who is a *member*. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico. Repairs and replacements are limited to once every three (3) years.

Pediatric Vision Expense Benefits

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

1. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or

e. Contact lenses (in lieu of glasses).

4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium);
    b. Intermediate vision lenses;
    c. Blended segment lenses;
    d. Hi-Index lenses;
    e. Plastic photosensitive lenses;
    f. Photochromic glass lenses;
    g. Glass-grey #3 prescription sunglass lenses;
    h. Fashion and gradient tinting;
    i. Ultraviolet protective coating;
    j. Polarized lenses;
    k. Scratch resistant coating;
    l. Anti-reflective coating (standard, premium or ultra);
    m. Oversized lenses;
    n. Polycarbonate lenses.
5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

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

Services not covered:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
   Non-network care without *prior authorization.*

Prescription Drug Expense Benefits

We work with providers and pharmacists to ensure that *we* cover medications used to treat a variety of conditions and diseases. *We* will accept uniform *prior authorization* forms for prescription drugs as sufficient to request *prior authorization* for prescription drug benefits.

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

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

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

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

Please note, not all dosage forms or strengths of a drug may be covered. The formulary 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.WesternSkyCommunityCare.com (under "For Member", "Pharmacy Resources") or call Member Services at 1-833-945-2029 (TDD/TTY 711).

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

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

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

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

Mail Order Pharmacy
If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for *your* regular *copayment*/*coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-239-7690. Alternatively, *you* can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on *our* Ambetter website. Once on *our* website, click on the section, "For Member," "Pharmacy Resources." The enrollment form will be located under "Forms."

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

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

1. For immunization agents, blood, or blood plasma, except when used for *preventive care* or required by ACA and listed on the formulary. This section does not preclude the coverage of aforementioned vaccines through the Medical Expense Benefits except for vaccines used in conjunction with travel to foreign counties.
2. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
3. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. Due to a *member's* addiction to, or dependency, on foods.
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 or when the over-the-counter drug is used for *preventive care*.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
9. For more than a 30-*day* supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-*day* supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-*day* supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharing* mail orders less than 90 days are subject to the standard *cost sharing* amount.
10. For *prescription drugs* for any *member* who enrolls in *Medicare* Part D as of the date of his or her enrollment in *Medicare* Part D. *Prescription drug* coverage may not be reinstated at a later date.
11. Off-label use, except as required by law or as expressly approved by *us*.
12. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.

13. Drugs or dosage amounts determined by Ambetter 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.
14. Foreign Prescription Medications, except those associated with an *emergency* medical condition while *you* are travelling outside the United States, or those *you* purchase while residing outside the United States, or those *you* purchase while residing outside the United States. These *exceptions* apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
15. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
16. For any claim submitted by non lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
17. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
18. For any injectable medication or biological product that is not expected to be self-administered by the *member* or *member's* place of residence unless listed on the formulary.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

External exception request review

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

the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.
If *we* grant an external exception review of a standard exception or step therapy protocol exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the exigency.

Preventive Care Expense Benefits

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

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

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. These recommendations include:
    a. Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;
    b. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese;
    c. Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a ≥10% 10-year cvd risk;
    d. Asymptomatic Bacteriuria in Adults: Screening: pregnant persons;
    e. BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation;
    f. Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer;
    g. Breast Cancer: Screening: women aged 50 to 74 years;
    h. Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children;
    i. Cervical Cancer: Screening: women aged 21 to 65 years;
    j. Colorectal Cancer: Screening: adults aged 50 to 75 years;
    k. Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
    l. Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
    m. Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;
    n. Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;

o. Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy;
p. Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation;
q. Chlamydia and Gonorrhea: Screening: sexually active women;
r. Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling: adults who are overweight or obese and have additional cvd risk factors;
s. Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;
t. Hepatitis B Virus Infection: Screening, 2014: persons at high risk for infection;
u. Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
v. Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
w. Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
x. High Blood Pressure in Adults: Screening: adults aged 18 years or older;
y. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
z. Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
aa. Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication : pregnant women who are at high risk for preeclampsia;
bb. Lung Cancer: Screening: adults aged 55-80, with a history of smoking;
cc. Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;
dd. Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
ee. Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
ff. Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
gg. Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
hh. Preeclampsia: Screening: pregnant woman;
ii. Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of hiv acquisition;
jj. Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
kk. Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women;
ll. Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
mm. Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults;
nn. Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children;
oo. Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10% or greater;

pp. Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
qq. Syphilis Infection in Pregnant Women: Screening: pregnant women;
rr. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
ss. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women;
tt. Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
uu. Unhealthy Drug Use: Screening: adults age 18 years or older;
vv. Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years;
ww. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults.

Note: The full list of recommendations and descriptions can be found at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations. Please be advised that these recommendations are subject to change. *Members* are encouraged to visit the website provided for the most up-to-date listing of recommendations.

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed *preventive care* and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional *preventive care* and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Childhood immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics, including coverage for all *medically necessary* booster doses of all immunizing agents used in childhood immunizations.
6. Covers without *cost sharing*:
    a. Screening for *tobacco or nicotine use*; and
    b. For those who *use tobacco or nicotine* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-*day* treatment regimen when prescribed by a health care *provider* without *prior authorization*.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *policy* when the

services are provided by a *participating provider.* If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you're* getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges.

Clinical Trial Coverage

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

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

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

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

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

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

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

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

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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

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

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

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

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

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

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

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

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

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

Duty to Cooperate

Members who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 *days* of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* in accordance with the notice requirements set forth in General Provisions herein. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborn Charges

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

Medical Foods

We cover medical foods and formulas for outpatient total parenteral nutritional therapy; nutritional counseling when prescribed by an in-network *medical practitioner*/*provider* and administered by enteral

tube feedings; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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

Newborns' and Mothers' Health Protection Act Statement of Rights
If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least once annually for a *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Covered Preventive Services for Women and Pregnant Women include:

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

Respite Care Expense Benefits

Respite care is covered on an *inpatient* or outpatient basis to allow temporary relief to family members from the duties of caring for a *covered person* under Hospice Care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. See *your Summary of Benefits and Coverage (SBC)* for coverage limits.

Radiology, Imaging and Other Diagnostic Testing

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

Second Medical Opinion

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

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *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 *participating provider* listed in the Healthcare Provider Directory. If a *member* chooses a *participating provider*, he or she will only be responsible for the applicable *copayment* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *copayment*.

Social Determinants of Health Supplemental Benefits

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

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services at 1-833-945-2029 (TDD/TTY 711).

Telehealth Service Benefits

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

telemedicine provider deems it necessary.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

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

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

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

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

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

These medical expenses are covered to the extent that the benefits remain and are available under the *member's contract,* 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 contract*.

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

1. *We* will pay for the following services when the *member* us required to travel more than 75 miles from the *residence* to the *Center of Excellence*
2. *We* will pay a maximum of $10,000 per *transplant* service for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the member's home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the member transplant reimbursement guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
    f. Please refer to the member resources page for member reimbursement transplant travel forms and information at www. Ambetter.com.

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

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.

g. *BMT* for Severe Combined Immunodeficiency.
h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
i. *BMT* for Myelodysplastic Syndrome.
j. *BMT* for Wiskott-Aldrich Syndrome.
k. *BMT* for Thalassemia Major.
l. *BMT* or *ABMT* for Multiple Myeloma.
m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
n. *BMT* for Fanconi's anemia.
o. *BMT* for malignant histiocytic disorders.
p. *BMT* for juvenile.

7. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to *FDA* oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for enrollee and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to member reimbursement under this policy:
    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, ect.)

d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
e. Storage rental units, temporary housing incurring rent/mortgage payments.
f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, ect.
g. Speeding tickets
h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
j. Expenses for persons other than the patient and his/her covered companion
k. Expenses for lodging when member is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck, and early check-in boarding fees, extra baggage fees.
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
r. All other items not described in the policy as eligible expenses
s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification

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

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

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

Limitations on Transplant Service Expense Benefits:

In addition to the *exclusions* and *limitations* specified elsewhere in this section:

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

Wellness Program Benefits

Benefits may be available to *members* for participating in certain programs that *we* may make available in connection with this *policy*. Such programs may include wellness programs, disease or *case management* programs, and other programs as found under the Health Management Programs Offered provision. These programs may include a reward or an incentive, which you may earn by completing different activities.

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services by telephone at 1-833-945-2029 (TTY/TDD 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by us through updates available on *our* website or by contacting *us*.

Care Management Programs

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

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

Your care manager will work with *you* and *your* doctor to help *you* get the care *you* need. If *you* have a severe medical condition, *your* care manager will with *you*, *your primary care provider (PCP)* and other *providers* to develop a care plan that meet *your* needs and *your* caregiver's needs. If *you* think *you* could benefit from *our* Care Management program, please call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

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

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

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

Covered service expenses 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*, except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric surgery and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-therapeutic abortion.
6. For expenses for television, telephone, or expenses for other persons.
7. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
8. For telephone consultations or for failure to keep a scheduled appointment.
9. For stand-by availability of a *medical practitioner* when no treatment is rendered.
10. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
11. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
12. For diagnosis or treatment of learning disabilities.
13. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
14. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
19. 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*.
20. For hearing aids, except as expressly provided in this *policy*.
21. 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.
22. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive *days*. If travel extends beyond 90 consecutive *days*, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 *days*.
23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this *exclusion* will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this *exclusion* will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
24. For or related to treatment of hyperhidrosis (excessive sweating).
25. For fetal reduction surgery.
26. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
27. 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).
28. 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.

29. 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.
30. 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 section; routine foot care except when related to diabetes, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
31. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
32. For court ordered testing or care unless *medically necessary*.
33. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party. surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This *exclusion* applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    (a) Prenatal care;
    (b) Intrapartum care (or care provided during delivery and childbirth);
    (c) Postpartum care (or care for the *surrogate* following childbirth);
    (d) Mental Health Services related to the *surrogacy arrangement*;
    (e) Expenses relating to donor semen, including collection and preparation for implantation;
    (f) Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    (g) Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    (h) Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    (i) Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    (j) Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.
34. For any medicinal and recreational use of cannabis or marijuana.

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

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

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

Termination

Termination of Policy

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. 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 Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace;
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. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes. If an HRA is offered, employer payments would be acceptable and exempt from the limitation;
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 Health Insurance Marketplace.

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 written notice, delivered, or mailed to the Exchange, or if an off-exchange *member* by written notice, delivered, or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 *days*. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

Reinstatement

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

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew 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 and refuse to renew 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.

Benefits After Coverage Terminates

Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*. The *period of extended loss* must begin before coverage of the *member* ceases under this *policy*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

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

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

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

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

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

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

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

the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

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

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

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

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

Coordination of Benefits

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

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

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

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

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

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

Effects of Coordination

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

Right to Receive and Release Needed Information

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

Claims

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

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

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

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

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

To request reimbursement for a *covered service*, *you* need a copy of the detailed claim from *your provider*. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at Ambetter.WesternSkyCommunityCare.com.com under "Member Resources." Send all the documentation to *us* at the following address:

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

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

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

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

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

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

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

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

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

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

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable *medical records* in English to show proper *proof of loss* and evidence of payment to the *provider*.

Assignment
We will reimburse a *hospital* or health care *provider* if:

1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

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

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

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

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

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

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

Upon request by the custodial parent, *we* will:

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

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

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

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

Summary of Health Insurance Grievance Procedures

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

1. Send a request in writing to Ambetter at:
   Ambetter from Western Sky Community Care, Inc.
   5300 Homestead Road NE
   Albuquerque, NM 87110
   Member Services: 1-833-945-2029 (TDD/TTY: 711)
   Fax: 1-833-886-7956
   Web address: Ambetter.WesternSkyCommunityCare.com
   Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM
2. From the OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

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

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

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

Review of an Adverse Determination

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

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

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

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

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

How long does initial certification take?
Standard decision: Ambetter must make an initial decision within 5 working days. However, Ambetter may extend the review period for a maximum of 10 calendar days if it:

1. Can demonstrate reasonable cause beyond *our* control for the delay;
2. Can demonstrate that the delay will not result in increased medical risk to *you*; and
3. Provide a written progress report and explanation for the delay to *you* and *your provider* within the original 5 working day review period.

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

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

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

must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

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

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

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

When will I be notified that my initial request has been either certified or denied?
If the initial request is approved, Ambetter must notify *you* and *your provider* within 1 working day after the decision, unless an urgent matter requires a quicker notice. If Ambetter denies certification, Ambetter must notify *you* and the *provider* within 24 hours after the decision.

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

Telephone: 1-833-945-2029
Address: Ambetter from Western Sky Community Care Grievances and Appeals Department
12515-8 Research Blvd., Ste. 400
Austin, TX 78759
FAX #: 1-833-751-0895
Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:
Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674

Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

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

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

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

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

How Long a First Level Review Takes

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

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

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

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

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

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

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

Ambetter will contact *you* with information about the panel's hearing date so that *you* may arrange to attend in person or by telephone, or arrange to have someone attend with *you* or on *your* behalf. *You* may review all of the information that Ambetter will provide to the panel and submit additional information that *you* want the panel to consider. If *you* attend the hearing in person or by telephone, *you* may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.
Ambetter's internal panel must complete its review within 30 days following *your* original request for an internal review of a request for pre-certification or within 60 days following *your* original request if *you* have already received the services. *You* will be notified within 1 day after the panel decision. If *you* fail to provide records or other information that Ambetter needs to complete the review, *you* will be given an opportunity to provide the missing items, but the review process may take much longer and *you* will be forced to wait for a decision.
Hint: If *you* need extra time to prepare for the panel's review, then *you* may request that the panel be delayed for a maximum of 30 days.

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

What's an IRO and what does it do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with Ambetter or with *you*. The reviewer will consider all of the information that is provided by Ambetter and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, Ambetter, and to OSI. Ambetter must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then Ambetter must provide them.
The IRO's fees are billed directly to Ambetter – there is no charge to you for this service.

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

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

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

Review of an Administrative Decision

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

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

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

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

If you are unable to prepare for the committee hearing within the time set by Ambetter, you may request that the committee hearing be postponed for up to 30 days.
The reconsideration committee will mail its decision to you within 7 days after the hearing.

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

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

General Information

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

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

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

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

General Provisions

Entire Policy

This *policy,* with the application, is the entire *policy* between *you* and *us.* No agent may:

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

Non-Waiver

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

Rescissions

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

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

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with State Laws

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

Personal Health Information

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

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPPA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like

the complete notice, please visit https://Ambetter.WesternSkyCommunityCare.com/privacy-practices.html or call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

We protect all of *your* PHI. *We* follow HIPPA to keep *your* healthcare information private.

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

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care , tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [Phone Number]

Navajo: Din4 k'ehj7 y1n7[ti'go ata' hane' n1 h0l= d00 naaltsoos t'11 Din4 k'ehj7 bee bik'e'ashch98go nich'8' 1dooln7i[go bee haz'3 a[d0' 1ko d77 t'11 1t'4 t'11 j77k'e k0t'4ego nich'8' 22'1t'4. Koj8' h0lne' [Phone Number]

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Western Sky Community Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi [Phone Number].

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer [PhoneNumber] an.

Chinese: 如果您，或是您正在協助的對象，有關於 Ambetter from Western Sky Community Care方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 [Phone Number]。

Arabic: إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Western Sky Community Care ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ [Phone Number].

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Western Sky Community Care에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [Phone Number] 로 전화하십시오.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa [Phone Number].

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

French: Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le [Phone Number]

Italian: Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Western Sky Community Care, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'[Phone Number].

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Western Sky Community Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону [Phone Number].

Hindi: आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Western Sky Community Care के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए [Phone Number] पर कॉल करें।

Persian: اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Western Sky Community Care دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره [Phone Number] تماس بگیرید.

Thai: หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข [Phone Number].

Statement of Non-Discrimination

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

Ambetter from Western Sky Community Care:

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

If you need these services, contact Ambetter from Western Sky Community Care at 1-833-945-2029 (TTY/TDD 711)

If you believe that Ambetter from Western Sky Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Western Sky Community Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
www.osi.state.nm.us

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

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

AMB20-NM-C-00189

Declaración de no discriminación

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

Ambetter from Western Sky Community Care:

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

Si necesita estos servicios, comuníquese con Ambetter from Western Sky Community Care a at 1-833-945-2029 (TTY/TDD 711)

Si considera que Ambetter from Western Sky Community Care no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo o fax. Si necesita ayuda para presentar una queja, Ambetter from Western Sky Community Care está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
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AMB20-NM-C-00189

ambetter. FROM western sky community care

2021 Evidence of Coverage

Ambetter.WesternSkyCommunityCare.com

Member Services Department: 1-833-945-2029 (TDD/TTY: 711)
Log on to: Ambetter.WesternSkyCommunityCare.com

Ambetter from Western Sky Community Care, Inc.

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

Major Medical Expense Insurance Policy

In this *policy,* the terms *"you"*, *"your",* or *"yours"* will refer to the *member* or any *dependents* named on the *Summary of Benefits and Coverage (SBC)*. The terms *"we," "our,"* or *"us"* will refer to Western Sky Community Care, Inc.

AGREEMENT AND CONSIDERATION

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

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

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

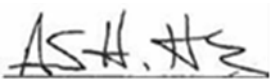
At least 60 *days'* notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *member's* health.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

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

TEN DAY RIGHT TO RETURN POLICY

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

Western Sky Community Care, Inc.



Antonio H. Hernandez
Plan President/CEO

TABLES OF CONTENTS

Introduction

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

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

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

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

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. MST
Member Services **1-833-945-2029**
TDD/TTY line **711**
Fax **1-833-751-0895**
Emergency **911**
24/7 Nurse Advice Line **1-855-604-1303** or for the hearing impaired (TDD/TTY 711)

Interpreter Services
Ambetter from Western Sky Community Care, Inc. 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. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

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

Member Rights and Responsibilities

We are committed to:

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

If *you* have difficulty locating a primary care provider, *specialist*, *hospital* or other contracted provider please contact us so that we can assist *you* with access or in locating a contracted Ambetter provider. Ambetter physicians may be affiliated with different hospitals. Our online directory can provide *you* with information on the Ambetter contracted hospitals. The online directory also lists affiliations that your provider may have with non-contracted hospitals. Your Ambetter coverage requires *you* to use contracted providers with limited *exceptions*.

You have the right to:

30. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
31. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
32. Receive the benefits for which *you* have coverage.
33. Have services available and accessible when *medically necessary*.
34. Have access to urgent and emergency care services 24 hours per day, seven days per week, and for other health care services as defined by the *policy*.
35. Be treated with courtesy and consideration, and with respect for the covered person's dignity and need for privacy.
36. Be provided with information concerning *our* policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
37. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
38. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
39. 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 practitioner* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care practitioner* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information

can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.

40. Make recommendations regarding *member's* rights, responsibilities, and policies.
41. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
42. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
43. See *your medical records*.
44. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care practitioner* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 *days* before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
45. Receive prompt notification of termination or changes in benefits, services or provider network.
46. A current list of *participating providers*.
47. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
48. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion.
49. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
50. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care practitioner's* instructions are not followed. *You* should discuss all concerns about treatment with *your primary care practitioner*. *Your primary care practitioner* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
51. A complete explanation of why care is denied.
52. An opportunity to appeal the denial decision to *us*, the right to a secondary appeal, and the right to request the superintendent's assistance.
53. Select *your primary care practitioner* within the *network*. *You* also have the right to change *your primary care practitioner* or request information on *participating providers* close to *your* home or work.
54. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your primary care practitioner*.
55. An interpreter when *you* do not speak or understand the language of the area.
56. A *second opinion* by a *network physician*, at no cost to *you*, if *you* believe your *participating provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
57. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
58. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care practitioner* 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:

17. Read this *policy* in its entirety.
18. Treat all health care professionals and staff with courtesy and respect.
19. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *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.
20. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
21. Show *your* ID 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.
22. Know the name of *your* assigned *primary care practitioner*. *You* should establish a relationship with *your physician*. *You* may change *your primary care practitioner* verbally or in writing by contacting *our* Member Services Department.
23. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
24. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
25. Supply, to the extent possible, information that *we* or *your* health care professionals and *physicians* need in order to provide care.
26. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
27. 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 practitioner* 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.
28. Follow all health benefit plan guidelines, provisions, policies, and procedures.
29. Use any *emergency* room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care practitioner*.
30. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
31. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost sharing percentages* at the time of service.
32. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 *days* from the date of the event.

Provider Directory

A listing of *participating providers* is available online at Ambetter.WesternSkyCommunityCare.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our participating 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, board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-833-945-2029 (TDD/TTY: 711). In order to obtain benefits, *you* must designate a *network primary care practitioner* for each *member. We* can also help *you* pick a *primary care practitioner* (*PCP*). *We* can make *your* choice of *primary care practitioner* effective on the next *business day*.

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

Member ID Card

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

The ID card will show *your* name, member ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-833-945-2029 (TDD/TTY: 711). *We* will send *you* another card.

Website

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

11. Finding a *participating provider*.
12. Locate other *providers* (e.g., *hospitals* and pharmacies)
13. *Our* programs and services, including programs to help *you* get and stay healthy.
14. A secure portal for *you* to check the status of *your* claims, make payments, and obtain a copy of *your* Member ID card.
15. Member Rights and Responsibilities.
16. Notice of Privacy Practices.
17. Current events and news.
18. *Our* Formulary or Preferred Drug List.
19. *Deductible* and *copayment* accumulators.
20. Selecting a *Primary Care Provider*.

Quality Improvement

We are committed to providing quality healthcare 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 Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

6. Conducting a thorough check on *physicians* when they become part of the *provider network*.
7. Providing programs and educational items about general healthcare and specific diseases.
8. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.

9. A Quality Improvement Committee which includes *participating providers* to help *us* develop and monitor *our* program activities.
10. Investigating any *member* concerns regarding care received.

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

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 healthcare and services *you* are receiving.

Definitions

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

Wherever used in this *policy*:

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

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

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

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

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

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

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

Authorization or ***Authorized*** (also "*Prior Authorization*" or "*Approval*") means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or provider group.

Autism spectrum disorder means *autism spectrum disorder* as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases (ICD-10).

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

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

Complications of pregnancy means:

3. 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 complication of *pregnancy*.
4. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *policy*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to

the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

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

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

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

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

Covered person means a subscriber, policyholder, or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

Custodial care is treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily *injury*.
Custodial care includes (but is not limited to) the following:

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

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

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

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

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

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

3. *You* satisfy *your* individual *deductible amount*; or

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

Dental services 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 *your* lawful *spouse* or an *eligible child*.

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 *covered person*, if that child is less than 26 years of age. As used in this definition, "child" means:

6. A natural child;
7. A legally adopted child;
8. A child placed with *you* for adoption;
9. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
10. A stepchild.

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

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

3. For *participating providers*: When a *covered service* is received from a *participating provider*, the *eligible service expense* is the contracted fee with that *provider*.
4. For *nonparticipating providers*:
    a. When a *covered service* is received from a *nonparticipating provider* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the greatest of the following:
        i. the amount that would be paid under *Medicare*,
        ii. the amount for the *covered service* calculated using the same method *we* generally use to determine payments for out-of-network services, or

iii. the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts.

Please note: *You* should not be balanced billed by the *provider*, if *you* are, please contact Member Services.

b. When a *covered service* is received from a *nonparticipating provider* as *approved* or *authorized* by *us* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*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 service expense* is the greater of (1) the amount that would be paid under *Medicare*, or (2) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.

c. When a *covered service* is received from a *nonparticipating provider* because the service or supply is not available from any *participating provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept 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 service expense* is the greater of (1) the amount that would be paid under *Medicare*, or (2) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.

d. Please note: In other circumstances, you may be balance billed if you knowingly choose to receive non-emergency care from a *nonparticipating provider*.

Emergency* (Medical, Behavioral Health, and Substance Use) *Services means covered *inpatient* and *outpatient services* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an *emergency* medical/behavioral health condition. An *emergency* medical/behavioral health medical 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:

5. Placing the physical or behavioral health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
6. Serious impairment to bodily functions;
7. Serious dysfunction of any bodily organ or part;
8. Serious harm to self or others due to an alcohol or drug use emergency; *Injury* to self or bodily harm to others; or with respect to a pregnant woman having contractions: (1) that there is inadequate

time to effect a safe transfer to another *hospital* before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

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

4. 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.
5. 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*.
6. A *physician* with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental or ***investigational treatment*** 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:

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

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

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

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

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

Facility means an entity providing health care service, including:

j. A general, specialized, psychiatric or rehabilitation *hospital*;
k. An *ambulatory surgical center*;
l. A cancer treatment center;
m. A birth center;
n. An impatient, outpatient or residential drug and alcohol treatment center;

o. A laboratory, diagnostic or other outpatient medical evaluation or testing center;
p. A health care *provider's* office or clinic;
q. An *urgent care center*; or
r. Any other therapeutic health care setting.

Generally accepted standards of medical practice are 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 any dissatisfaction with 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 including any of the following:

5. Provision of services.
6. Determination to rescind a *policy*.
7. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*.
8. Claims practices.

Habilitation or ***habilitation services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or outpatient settings.

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

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

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

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

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

4. Prescribed and supervised by a *physician*.

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

5. Operates pursuant to law as a *home health care agency*;
6. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
7. Maintains a daily *medical record* on each patient; and
8. 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 refers to services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by an Ambetter physician. Ambetter works with certified hospice programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of terminally ill *members* and their *immediate family*.

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

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

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

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

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

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

Listed transplant means one of the following procedures and no others:

7. Heart transplants.
8. Lung transplants.
9. Heart/lung transplants.
10. Kidney transplants.
11. Liver transplants.
12. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

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

Loss of minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

8. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
9. In the case of coverage offered through an *HMO*, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual);
10. In the case of coverage offered through an *HMO*, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of

coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual), and no other benefit package is available to the individual;
11. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
12. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual;
13. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
14. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance* percentage of *covered expenses*, as shown in the *Summary of Benefits and Coverage (SBC)*. After the *maximum out-of-pocket amount* is met for an individual, Western Sky Community Care, Inc. pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Summary of Benefits and Coverage (SBC)*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any *covered persons' eligible service expenses*. A *covered person's maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket amount*.

If *you* are a covered *member* in a family of two or more *members*, *you* will satisfy *your maximum out-of-pocket* when:
3. *You* satisfy *your* individual *maximum out-of-pocket*; or
4. *Your* family satisfies the family *maximum out-of-pocket amount* for the *calendar year*.

If *you* satisfy *your* individual *maximum out-of-pocket*, *you* will not pay any more *cost sharing* for the remainder of the *calendar year*, but any other eligible *members* in *your* family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the *calendar year*.

The dental out-of-pocket maximum limits do not apply to the satisfaction of the *maximum out-of-pocket* per *calendar year* as shown in the *Summary of Benefits and Coverage (SBC)*.

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

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

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

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

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

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

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

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

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

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from *Medicare* for treating *Medicare*-eligible individuals.

Member means an individual covered by the health plan including an enrollee, subscriber, or policyholder.

Mental disorder means a behavioral, emotional, or cognitive disorder that is listed in the most recent edition of the International Classification of Diseases.

Necessary medical supplies means medical supplies that are:

4. Necessary to the care or treatment of an *injury* or *illness*;
5. Not reusable or *durable medical equipment*; and
6. 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 the group or groups of *participating providers* who provide health care services under a network plan.

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

Non-elective caesarean section means:

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

Nonparticipating provider means a *provider* who is not a *participating provider* as defined. Also known as an out-of-*network provider* or non-contracted *provider*.

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

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

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

rehabilitation, or other *provider facility* as determined by *us*. Professional charges only include services billed by a *physician* or other professional.

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

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

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

Period of extended loss means a period of consecutive days:

3. Beginning with the first *day* on which a *member* is a *hospital inpatient;* and
4. Ending with the 30th consecutive *day* for which he or she is not a *hospital inpatient.*

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

Policy when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Post-service claim means a claim submitted to a health insurance carrier by or on behalf of a *covered person* after health care services have been provided to the *covered person*.

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

6. the Chiropractic Physician Practice Act
7. the Dental Health Care Act
8. the Medical Practice Act
9. Chapter 61, Article 10 NMSA 1978; and
10. The Acupuncture and Oriental Medicine Practice Act

Note: *Practitioner of the healing arts* could be a *primary care practitioner (PCP)*

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

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

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

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

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

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

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

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

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

Prosthetic device means an artificial leg or arm.

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

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

Qualified health plan or ***QHP*** means a major medical plan that has been reviewed and deemed by the superintendent to provide *essential health benefits*, follow established limits on cost-sharing, provide "minimum essential coverage" and meet the other requirements of the Affordable Care Act.

Reconstructive surgery means *surgery* from which an improvement in physiological function could reasonably be expected, when ordered by a *member's* primary care practitioner or treating health care professional and performed for the correction of functional disorders resulting from accidental *injury* or from congenital defects or disease.

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

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

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

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

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

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

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:

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

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

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

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

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

Specialist physician means a *physician* who is not a *primary care practitioner.*

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

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

Spouse means *your* lawful wife or husband.

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance use disorders* are those listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases (ICD-10).

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

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

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

Surprise bill reimbursement rate means the sixtieth (16th) percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit

organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill reimbursement rate shall be paid at less than one hundred fifty percent (150%) of the 2017 Medicare reimbursement rate for the applicable health care service provided.

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

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

Surveillance tests for ovarian cancer means annual screening using:

4. CA-125 serum tumor marker testing;
5. Transvaginal ultrasound; or
6. Pelvic examination.

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

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

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

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

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

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

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

3. *"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.
4. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

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

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

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

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

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

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

Enrollment and Eligibility

An individual must be enrolled as a *member* under this *policy* for *covered services* to be available. To enroll and become a *member*, an individual must:

1. Live or work in the Service Area, as determined by Ambetter;
2. Not be incarcerated, other than incarceration pending disposition of charges;
3. Not be eligible for *Medicare* due to age, illness, or disability;
4. Apply during an open enrollment period or within 60 days of a qualifying event as described in Special and Limited Enrollment section of this *policy*; and
5. Pay the premium due prior to the coverage *effective date*.

Note: *Members* who are Ending Stage Renal Disease (ESRD) patients have the choice of whether to enroll in *Medicare* or retain commercial coverage despite their eligibility for *Medicare*.

Dependent Member Coverage

Dependent Member Eligibility

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

7. The date *you* became covered under this *policy;*
8. The date of marriage to add a *spouse*;
9. The date of an eligible newborn's birth; or
10. 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.
11. The date you are required by a court order or administrative order to provide coverage for an eligible child; or
12. The date you are required to provide coverage for a dependent student due to medically necessary leave of absence.

Effective Date for Initial Dependent Members

The *effective date* for *your* initial *dependent members,* if any, is shown on the *Summary of Benefits and Coverage (SBC)*. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for a Newborn Child

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

Covered services for a newborn child include:

6. *Injury* or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care facility for newly born infants
7. Newborn visits in the *hospital* by the newborn's *primary care practitioner*

8. Circumcision for newborn males
9. Coverage for incubator
10. Routine *hospital* nursey charges

Additional premium will be required to continue coverage beyond the 31st *day* after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* within the 31 *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 within 60 *days* of the birth of the child, the *policy* 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 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. 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 within 60 *days* of the birth or placement and (B) any additional premium required for the addition of the child within 90 *days* of the date of *placement.*

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

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

Coverage for a Child Born Out of Wedlock

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

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

Coverage for a Child with Coverage through Insurance of Noncustodial Parent

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

4. Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;
5. Permit the custodial parent or the *provider*, with the custodial parent's approval, to submit claims for *covered services* without the approval of the noncustodial parent; and

6. Make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the provider or the state Medicaid agency.

Court Order to Provide Child Coverage

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

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

Adding Other Dependent Members

If *you* are enrolled in an off-exchange policy and apply in writing 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 ID cards for the added *dependent*.

Ongoing Eligibility

For All Members

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

8. 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*;
9. The date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
10. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
11. The date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request;
12. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this contract or the date that *we* have not received timely premium payments in accordance with the terms of this contract;
13. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g. the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract); or
14. The date of a *member's* death.

For Dependent Members

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

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

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

Open Enrollment

Each year there will be an open enrollment period for coverage. The open enrollment period begins November 1, 2020 and extends through December 15, 2020. Qualified individuals who enroll on or before December 15, 2020 will have an *effective date* of coverage on January 1, 2021.

Special and Limited Enrollment

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

18. A *qualified individual* or *dependent loses minimum essential coverage,* non-*calendar year* group or individual health insurance coverage, *pregnancy*-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;

19. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order;
20. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
21. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
22. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer or employee, or its instrumentalities as evaluated and are determined by *us*. In such cases, *we* may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
23. An enrollee adequately demonstrates to *us* that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its policy in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
24. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a chance in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
25. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
26. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
27. 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;
28. A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA);
29. An enrollee loses access to their Marketplace plan as a result of death;
30. An enrollee loses access to their Marketplace plan as a result of divorce or legal separation;
31. Current employer plan no longer considered qualifying employer coverage;
32. An enrollee loses eligibility for Medicaid, Medicare or CHIP; or
33. An enrollee is a survivor of domestic violence, abuse or spousal abandonment.

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 ten (10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing

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

5. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
6. Indian tribes, tribal organizations, or urban Indian organizations;
7. State and Federal government programs; or
8. Family members.

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 subscription charges remain due.

Similarly, if we determine payment was made for *deductibles* or *cost sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a third party premium payment that may not be counted towards your *deductible* or maximum-out-of-pocket costs.

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

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 *days* of the change. As a result *your* premium may change and *you* may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

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

Prior Authorization

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

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

Prior Authorization Required

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

For services or supplies that require *prior authorization*, as shown on the *Summary of Benefits and Coverage (SBC)*, *you* must obtain *authorization* from *us* before *you* or *your dependent member:*

3. Receive a service or supply from a *nonparticipating provider;* or
4. Receive a service or supply from a *participating provider* to which *you* or *your dependent member* were referred to by a *nonparticipating provider.*

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

Prior Authorization requests must be received by phone/efax/ Provider portal as follows:

6. At least 7 *days* prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* facility.
7. At least 7 *days* prior to the initial evaluation for organ transplant services.
8. At least 7 *days* prior to receiving clinical trial services.
9. Within 24 hours of an admission for *inpatient* mental health or *substance abuse* treatment.
10. At least 7 *days* prior to the start of *home health care*.

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

6. For immediate request situations, within 1 *business day*, when the lack of treatment may result in an emergency room visit or *emergency* admission.
7. For urgent concurrent reviews within 24 hours of receipt of the request.
8. For urgent *pre-service* reviews, within 72 hours from date of receipt of request.
9. For non-urgent *pre-service* reviews within 5 *days*, but no longer than 15 *days*, of receipt of the request.
10. For post-service or retrospective reviews, within 30 calendar *days* of receipt of the request.

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

Failure to Obtain Prior Authorization
Failure to comply with the *prior authorization* requirements may result in denial of payment.

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

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

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

Services Requiring Prior Authorization
38. Adult Accidental Dental
39. Bariatric Surgery Inpatient
40. Bone Anchored Hearing Aids
41. Cardiac Rehabilitation
42. Cochlear Implants
43. Corrective Footwear Orthotics Shoes Inserts
44. Delin Inpatient Services Maternity Care
45. Diabetic Footwear
46. Diabetic Footwear Orthotics
47. Durable Medical Equipment
48. Hearing Aid Supplies Batteries
49. Home Healthcare
50. Imaging
51. Infertility Diagnostic Testing
52. Inherited Metabolic Disorder
53. Inpatient Facility Admission
54. Inpatient Mental Health
55. Inpatient Rehabilitation
56. Inpatient Substance Use
57. Mastectomy Bra

58. Neurodevelopmental Therapy
59. Neurological Rehabilitation
60. Outpatient Rehabilitation
61. Outpatient Substance Use
62. Outpatient Surgery Doctor
63. Outpatient Surgery Facility
64. Private Duty Nursing
65. Respite Care
66. Rx Preferred Drug
67. Rx Specialty Drug
68. Rx Specialty Mail Drug
69. Specialist Visit
70. Skilled Nursing Facility
71. Sleep Study
72. TMJ Treatment
73. Transplant
74. Wigs

Cost Sharing Features

Cost Sharing Features

We will pay benefits for *covered services* as described in the *Summary of Benefits of Coverage (SBC)* and the Covered Services sections of this Contract. All benefits *we* pay will be subject to all conditions, *limitations*, and *cost sharing* features of this Contract. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, *you* may need to pay a *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 Summary of Benefits of Coverage (SBC)*.

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

Copayments

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

Coinsurance Percentage

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

Deductible

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

Refer to your Summary of Benefits and Coverage (SBC) for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

3. Any specific benefit limits stated in the *policy*; and
4. A determination of *eligible service expenses*.

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

Note: The bill *you* receive for services or supplies from a *nonparticipating provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing percentage*, *you* are responsible for the difference between the *eligible service expense* and the amount the *nonparticipating provider* bills *you* for the services or supplies. Any amount *you* are obligated to pay to the *nonparticipating provider* in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

Access to Care

Primary Care Provider

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

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

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

Any female *member* age 13 or older may designate an OB/GYN as a *network primary care practitioner*. *You* may obtain a list of *network primary care practitioners* at *our* website and using the "Find a Provider" function or by contacting *our* Member Services department.

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

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

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

Changing Your Primary Care Practitioner

You may change *your network primary care practitioner* by submitting a written request, online at *our* website, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care practitioner* of record will be effective no later than 30 *days* from the date *we* receive *your* request.

Contacting Your Primary Care Practitioner
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. At every appointment, make sure *you* bring *your member* ID card and a photo ID.

Should *you* need care outside of *your* PCP's office hours, *you* should call *your* PCP's office for information on receiving after hours care in your area. If *you* have an urgent medical problem or question or cannot reach *your* PCP during normal office hours, call *our* 24/7 nurse advice line at 1-877-687-1180 (TTY/TDD 1-877-941-9231). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

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

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *participating providers*. *You* will be notified of any increase in premium.

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

Non-Emergency Services
If you are traveling outside of the New Mexico service area *you* may be able to access providers in another state. *You* can locate Ambetter providers outside of New Mexico by searching the relevant state in our directory at ProviderSearch.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* ID card for further information.

Emergency Services Outside of Service Area
We cover emergency care services when *you* are outside of *our* service area.

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

New Technology

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

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

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

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

Major Medical Expense Benefits

Ambulance Service Benefits

Covered service expenses will include *ambulance services* for local transportation:

5. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
6. Transportation, including air transport, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest tertiary care *facility*.
7. 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.
8. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by *us*.

Benefits for air *ambulance services* are limited to:

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

Exclusions:
No benefits will be paid for:

6. Expenses incurred for *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
7. Non-*emergency* air ambulance.
8. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
9. *Ambulance services* provided for a *member's* comfort or convenience.
10. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Autism Spectrum Disorder Benefits

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

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

- evaluation and assessment services;
- *applied behavior analysis*;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy;
- *habilitation* services with a diagnosis of *autism spectrum disorder*; or

- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Coronavirus; COVID-19 Public Health Emergency

Coverage includes testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency as long as the public health emergency remains in effect, either declared by the state of New Mexico or federal government.
There is *no member cost sharing* requirements for testing and/or delivery of healthcare services that are related to COVID-19.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, diabetes education when received from a *medical practitioner*/*provider* who is approved to provide diabetes education; exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
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.

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices

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

- The equipment, supply, or appliance is a *covered service*;
- The continued use of the item is *medically necessary*; and
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is

not reasonable justification).

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

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

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

9. Hemodialysis equipment.
10. Crutches and replacement of pads and tips.
11. Pressure machines.
12. Infusion pump for IV fluids and medicine.
13. Glucometer.
14. Tracheotomy tube.
15. Cardiac, neonatal, and sleep apnea monitors.
16. Augmentive communication devices are covered when *we approve* based on the *member's* condition.

Exclusions:

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

8. Air conditioners.
9. Ice bags/coldpack pump.

10. Raised toilet seats.
11. Rental of equipment if the *member* is in a *facility* that is expected to provide such equipment.
12. Translift chairs.
13. Treadmill exerciser.
14. Tub chair used in shower.

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

Medical and surgical supplies

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

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

6. Allergy serum extracts.
7. Chem strips, Glucometer, Lancets.
8. Clinitest.
9. Needles/syringes.
10. 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:

8. Adhesive tape, band aids, cotton tipped applicators.
9. Arch supports.
10. Doughnut cushions.
11. Hot packs, ice bags.
12. Vitamins (except as provided for under Preventive benefits).
13. Medijectors.
14. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Orthotic devices

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

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

10. Cervical collars.
11. Ankle foot orthosis.
12. Corsets (back and special surgical).
13. Splints (extremity).
14. Trusses and supports.
15. Slings.
16. Wristlets.

17. Built-up shoe.
18. Custom made shoe inserts.

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

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

5. Orthopedic shoes (except therapeutic shoes for diabetics).
6. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
7. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted (except as specified under Medical Supplies).
8. Garter belts or similar devices.

<u>Prosthetics</u>
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:

3. Replace all or part of a missing body part and its adjoining tissues; or
4. 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:

9. 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.
10. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
11. 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.
12. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
13. 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.

14. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
15. Restoration prosthesis (composite facial prosthesis).
16. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

*Exclusion*s:
Non-covered prosthetic appliances include, but are not limited to:

6. Dentures, replacing teeth, or structures directly supporting teeth.
7. Dental appliances.
8. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
9. Wigs (except as described above following cancer treatment).
10. Penile prosthesis in adults suffering impotency resulting from disease or *injury*.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

6. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
7. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 *days* of a *hospital* stay of at least 3 consecutive *days* and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
8. *Covered service expenses* 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 U.S. Food and Drug Administration.
9. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
10. Outpatient rehabilitative physical therapy, occupational therapy, and speech therapy.

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

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

5. The *member* has reached *maximum therapeutic benefit*.
6. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
7. There is no measurable progress toward documented goals.
8. 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* in-*network* care provided at the *member's* home and includes the following:

9. *Home health aide services*.
10. Services of a private duty registered nurse or licensed practical nurse rendered on an outpatient basis. Please refer to *your Summary of Benefits and Coverage (SBC)* for any limits associated with this *benefit*.
11. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
12. I.V. medication and pain medication.
13. Hemodialysis, and for the processing and administration of blood or blood components.
14. *Necessary medical supplies*, drugs and medicines, and laboratory services, to the extent they would have been covered if provided to the *member* on an impatient basis.
15. Rental of *medically necessary durable medical equipment*.
16. Sleep studies.

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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.

Limitations:
See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits for expenses related to *home health aide services*.

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

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a hospice care program. *Covered services* and supplies include:

9. Room and board in a *hospice* while the *member* is an *inpatient.*
10. Occupational therapy.
11. Speech-language therapy.
12. The rental of medical equipment while the *terminally ill covered person* is in a hospice care program to the extent that these items would have been covered under the *policy* if the *member* had been confined in a *hospital.*
13. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
14. Counseling the *member* regarding his or her *terminal illness.*

15. *Terminal illness counseling* of the *member's immediate family.*
16. *Bereavement counseling.*

Benefits for *hospice inpatient*, home and outpatient care are available.

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

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

Hospital Benefits

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

7. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
8. Daily room and board and nursing services while confined in an *intensive care unit*.
9. *Inpatient* use of an operating, treatment, or recovery room.
10. Outpatient use of an operating, treatment, or recovery room for *surgery.*
11. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
12. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your Summary of Benefits and Coverage (SBC)* for *limitations*.

Emergency Room Services

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

Medical Expense Benefits

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

22. Made by a *physician* or *specialist* for professional services, including *surgery*.
23. For the professional services of a *medical practitioner*.
24. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
25. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included) which includes but are not limited to:
    1. Sleep disorder studies in home or facility which may require *prior authorization*;
    2. Bone density studies;
    3. Clinical laboratory tests;
    4. Gastrointestinal lab procedures;
    5. Pulmonary function tests.
26. For chemotherapy and radiation therapy or treatment.

27. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
28. For the cost and administration of an anesthetic.
29. For oxygen and its administration.
30. For *medically necessary chiropractic care* and acupuncture treatment on an outpatient basis only. Coverage limited to 20 visits/calendar year, unless it is habilitative and rehabilitative in nature. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
31. Family Planning for certain professional *provider* contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
32. *Medically necessary services* made by a *physician* in an *urgent care center*, including *facility* costs and supplies.
33. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
34. Allergy services including testing and sera.
35. Allergy serum extracts.
36. *Medically necessary telehealth* services subject to the same clinical and *utilization review* criteria, plan requirements, *limitations* and *cost sharing* as the same health care services when delivered to an insured in person.
37. For *medically necessary* genetic blood tests.
38. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
39. For *medically necessary* biofeedback services.
40. For *medically necessary* allergy treatment.
41. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
42. *Telehealth* services are covered for medical outpatient services and mental health and substance use disorder outpatient services.

Surgical Expense Benefits

Surgical *covered services* but not limited to charges:

9. For *surgery* in a *physician's* office, inpatient facility, or at an *outpatient surgical facility,* including services and supplies.
10. Made by an assistant surgeon.
11. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
12. For *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
13. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
14. Bariatric surgery for *members* with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at risk

for increased morbidity due to specific obesity related comorbid medical conditions.

15. Accidental Dental.
16. 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.

Mental Health and Substance Use Disorder Benefits

Our behavioral health and substance use vendor oversees the delivery and oversight of covered behavioral health and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our* behavioral health and substance use vendor's *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *You* can search for in-network Behavioral Health *providers* by using *our* Find a Provider tool at Ambetter.WesternSkyCommunityCare.com or by calling Member Services at 1-833-945-2029 (TDD/TTY 711). *Deductible amounts*, *copayment,* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most recent edition of the International Classification of Diseases (ICD-10).

When making coverage determinations, *our* behavioral health and substance use vendor utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and substance use vendor utilizes Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance abuse* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

8. *Inpatient* detoxification treatment;
9. Observation;
10. Crisis Stabilization;
11. *Inpatient rehabilitation*;
12. *Residential treatment facility* for mental health and *substance abuse*;

13. *Inpatient* Psychiatric Hospitalization; and
14. Electroconvulsive Therapy (ECT).

Outpatient

14. Individual and group mental health evaluation and treatment;
15. *Outpatient services* for the purpose of monitoring drug therapy;
16. Medication management services;
17. Outpatient detoxification programs;
18. Psychological and Neuropsychological testing and assessment;
19. Outpatient *rehabilitation* treatment;
20. *Applied Behavioral Analysis*;
21. Telemedicine;
22. Partial Hospitalization Program (PHP);
23. Intensive Outpatient Program (IOP);
24. Mental health day treatment;
25. Electroconvulsive Therapy (ECT);
26. *Transcranial Magnetic Stimulation (TMS)*

In addition, Integrated Care Management is available for all of *your* healthcare needs, including behavioral health and substance use. Please call 1-866-263-8134 (TDD/TTY 1-855-868-4945) to be referred to a care manager for an assessment.

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

Other Dental Services

Anesthesia and *hospital* charges for dental care are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient *ambulatory surgical center* for the following:

1. *Members* exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
2. *Members* for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
3. *Eligible child* who is extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral dental morbidity;
4. *Members* with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
5. Other procedures for which hospitalization or general anesthesia in a *hospital* or *ambulatory surgical center* is *medically necessary*.

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. This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

Other *dental services* shall be limited to the following conditions when deemed *medically necessary*:

6. Accidental *injury* to sound natural teeth, jaw bones, or surrounding tissues;
7. Correction of a non-dental physiological condition which has resulted in a severe functional impairment; or
8. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth

Outpatient Medical Supplies Expense Benefits

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

9. 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.
10. For one pair of foot orthotics per year per *covered person*.
11. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
12. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
13. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
14. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
15. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery.
16. For the cost of one hearing aid per *eligible child* under the age of 18 (or under the age of 21 if still attending high school) who is a *member*. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico. Repairs and replacements are limited to once every three (3) years.

Pediatric Vision Expense Benefits

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

6. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
7. Frames
8. Prescription lenses
    a. Single;

b. Bifocal;
c. Trifocal;
d. Lenticular; or
e. Contact lenses (in lieu of glasses).

9. 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.
10. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

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

Services not covered:

3. Visual therapy;
4. Two pair of glasses as a substitute for bifocals;
   Non-network care without *prior authorization.*

Prescription Drug Expense Benefits

We work with providers and pharmacists to ensure that *we* cover medications used to treat a variety of conditions and diseases. *We* will accept uniform *prior authorization* forms for prescription drugs as sufficient to request *prior authorization* for prescription drug benefits.

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

5. A *prescription drug.*
6. Prescribed, self-administered anticancer medication.
7. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
8. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or

b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

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

Please note, not all dosage forms or strengths of a drug may be covered. The formulary 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.WesternSkyCommunityCare.com (under "For Member", "Pharmacy Resources") or call Member Services at 1-833-945-2029 (TDD/TTY 711).

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

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

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

We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high

blood pressure, asthma and diabetes. *You* can find a list of covered medications on Ambetter.WesternSkyCommunityCare.com. *You* can also request to have a copy mailed directly to *you*.

Mail Order Pharmacy

If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for *your* regular *copayment*/*coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-239-7690. Alternatively, *you* can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on *our* Ambetter website. Once on *our* website, click on the section, "For Member," "Pharmacy Resources." The enrollment form will be located under "Forms."

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

Non-Covered Services and *Exclusion*s:

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

19. For immunization agents, blood, or blood plasma, except when used for *preventive care* or required by ACA and listed on the formulary. This section does not preclude the coverage of aforementioned vaccines through the Medical Expense Benefits except for vaccines used in conjunction with travel to foreign counties.
20. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
21. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
22. For a refill dispensed more than 12 months from the date of a *physician's* order.
23. Due to a *member's* addiction to, or dependency, on foods.
24. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
25. 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 or when the over-the-counter drug is used for *preventive care*.
26. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
27. For more than a 30-*day* supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-*day* supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-*day* supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharing* mail orders less than 90 days are subject to the standard *cost sharing* amount.
28. For *prescription drugs* for any *member* who enrolls in *Medicare* Part D as of the date of his or her enrollment in *Medicare* Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. Off-label use, except as required by law or as expressly approved by *us*.

30. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
31. Drugs or dosage amounts determined by Ambetter 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.
32. Foreign Prescription Medications, except those associated with an *emergency* medical condition while *you* are travelling outside the United States, or those *you* purchase while residing outside the United States, or those *you* purchase while residing outside the United States. These *exceptions* apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
33. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
34. For any claim submitted by non lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
35. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
36. For any injectable medication or biological product that is not expected to be self-administered by the *member* or *member's* place of residence unless listed on the formulary.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make *our* determination on the external exception request and notify the *member*, the *member's* designee or the

member's prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.
If *we* grant an external exception review of a standard exception or step therapy protocol exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the exigency.

Preventive Care Expense Benefits

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

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

7. 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. These recommendations include:
    a. Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;
    b. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese;
    c. Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a ≥10% 10-year cvd risk;
    d. Asymptomatic Bacteriuria in Adults: Screening: pregnant persons;
    e. BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation;
    f. Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer;
    g. Breast Cancer: Screening: women aged 50 to 74 years;
    h. Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children;
    i. Cervical Cancer: Screening: women aged 21 to 65 years;
    j. Colorectal Cancer: Screening: adults aged 50 to 75 years;
    k. Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
    l. Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
    m. Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;

n. Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;
o. Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy;
p. Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation;
q. Chlamydia and Gonorrhea: Screening: sexually active women;
r. Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling: adults who are overweight or obese and have additional cvd risk factors;
s. Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;
t. Hepatitis B Virus Infection: Screening, 2014: persons at high risk for infection;
u. Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
v. Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
w. Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
x. High Blood Pressure in Adults: Screening: adults aged 18 years or older;
y. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
z. Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
aa. Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication : pregnant women who are at high risk for preeclampsia;
bb. Lung Cancer: Screening: adults aged 55-80, with a history of smoking;
cc. Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;
dd. Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
ee. Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
ff. Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
gg. Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
hh. Preeclampsia: Screening: pregnant woman;
ii. Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of hiv acquisition;
jj. Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
kk. Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women;
ll. Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
mm. Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults;
nn. Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children;

oo. Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10% or greater;
pp. Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
qq. Syphilis Infection in Pregnant Women: Screening: pregnant women;
rr. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
ss. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women;
tt. Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
uu. Unhealthy Drug Use: Screening: adults age 18 years or older;
vv. Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years;
ww. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults.

Note: The full list of recommendations and descriptions can be found at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations. Please be advised that these recommendations are subject to change. *Members* are encouraged to visit the website provided for the most up-to-date listing of recommendations.

8. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
9. Evidence-informed *preventive care* and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
10. Additional *preventive care* and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
11. Childhood immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics, including coverage for all *medically necessary* booster doses of all immunizing agents used in childhood immunizations.
12. Covers without *cost sharing*:
    a. Screening for *tobacco or nicotine use*; and
    b. For those who *use tobacco or nicotine* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-*day* treatment regimen when prescribed by a health care *provider* without *prior authorization*.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *policy* when the services are provided by a *participating provider.* If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you're* getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges.

Clinical Trial Coverage

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

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

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

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

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

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

In a clinical trial, the treating *facility* and personnel must have the expertise and training to provide the

treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.
Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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

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

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

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

Maternity Care
Coverage for outpatient and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be

provided for maternity services or care of the newborn child when such services have been *authorized* by *your* participating health care *provider*.

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

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

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

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

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

Duty to Cooperate

Members who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 *days* of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* in accordance with the notice requirements set forth in General Provisions herein. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborn Charges

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

Medical Foods

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

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

Newborns' and Mothers' Health Protection Act Statement of Rights
If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least once annually for a *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

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

Respite Care Expense Benefits

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

deductible amount are considered benefits provided and shall apply against any maximum benefit limit for these services. See *your Summary of Benefits and Coverage (SBC)* for coverage limits.

Radiology, Imaging and Other Diagnostic Testing

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

Second Medical Opinion

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

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

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

Social Determinants of Health Supplemental Benefits

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

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services at 1-833-945-2029 (TDD/TTY 711).

Telehealth Service Benefits

Telehealth services are covered for medical outpatient services and mental health and substance use disorder outpatient services. *Telehealth* services are covered on the same basis and to the same extent that

we would otherwise provide coverage for the same service when provided through an in-person consultation or contact and the type of setting where these services are provided is not limited. An in-person consultation or contact is not required for coverage of *telehealth services* unless the consulting telemedicine provider deems it necessary.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

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

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

5. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
6. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollees benefits.
7. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this contract will be provided for you. However, no benefits will be provided for the recipient.
8. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

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

10. Pre-transplant evaluation.
11. Pre-transplant harvesting of the organ from the donor.
12. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
13. 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.
14. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
15. 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 participating facility.
16. Post-transplant follow-up visits and treatments.
17. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.

18. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations.

These medical expenses are covered to the extent that the benefits remain and are available under the *member's contract,* 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 contract*.

Ancillary "Center Of Excellence" Service Benefits:

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

3. *We* will pay for the following services when the *member* us required to travel more than 75 miles from the *residence* to the *Center of Excellence*
4. *We* will pay a maximum of $10,000 per *transplant* service for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the member's home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the member transplant reimbursement guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
    f. Please refer to the member resources page for member reimbursement transplant travel forms and information at www. Ambetter.com.

Covered Transplant Expense Benefits:

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

8. Heart transplants.
9. Lung transplants.
10. Heart/lung transplants.
11. Kidney transplants.
12. Liver transplants.
13. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.

d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
e. *BMT* for Chronic Myelogenous Leukemia.
f. *ABMT* for Testicular Cancer.
g. *BMT* for Severe Combined Immunodeficiency.
h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
i. *BMT* for Myelodysplastic Syndrome.
j. *BMT* for Wiskott-Aldrich Syndrome.
k. *BMT* for Thalassemia Major.
l. *BMT* or *ABMT* for Multiple Myeloma.
m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
n. *BMT* for Fanconi's anemia.
o. *BMT* for malignant histiocytic disorders.
p. *BMT* for juvenile.

14. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.

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

11. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
12. For animal to human transplants.
13. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
14. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence*.
15. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
16. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
17. 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 ("USFDA") regulation, regardless of whether the trial is subject to *FDA* oversight.
18. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence*.
19. For any transplant services and/or travel related expenses for enrollee and donor, when preformed outside of the United States.
20. The following ancillary items listed below, will not be subject to member reimbursement under this policy:
    a. Alcohol/tobacco

b. Car Rental (unless pre-approved by Case Management)
c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
e. Storage rental units, temporary housing incurring rent/mortgage payments.
f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
g. Speeding tickets
h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
j. Expenses for persons other than the patient and his/her covered companion
k. Expenses for lodging when member is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
r. All other items not described in the policy as eligible expenses
s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification
At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving *immunosuppressant drugs* or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, *We* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or guardian if the patient is a child, or the *spouse* of a patient who is *authorized* to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.
As an alternative to providing written notice, *we* may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.
At the time a patient requests a refill of the immunosuppressant drug, *we* may provide the patient with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

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

4. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.

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

Wellness Program Benefits

Benefits may be available to *members* for participating in certain programs that *we* may make available in connection with this *policy*. Such programs may include wellness programs, disease or *case management* programs, and other programs as found under the Health Management Programs Offered provision. These programs may include a reward or an incentive, which you may earn by completing different activities.

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services by telephone at 1-833-945-2029 (TTY/TDD 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by us through updates available on *our* website or by contacting *us*.

Care Management Programs

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

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

Your care manager will work with *you* and *your* doctor to help *you* get the care *you* need. If *you* have a severe medical condition, *your* care manager will with *you*, *your primary care provider (PCP)* and other *providers* to develop a care plan that meet *your* needs and *your* caregiver's needs. If *you* think *you* could benefit from *our* Care Management program, please call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

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

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

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

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

35. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
36. For any portion of the charges that are in excess of the *eligible service expense.*
37. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric surgery and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
38. For the reversal of sterilization and the reversal of vasectomies.
39. For non-therapeutic abortion.
40. For expenses for television, telephone, or expenses for other persons.
41. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
42. For telephone consultations or for failure to keep a scheduled appointment.
43. For stand-by availability of a *medical practitioner* when no treatment is rendered.
44. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
45. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
46. For diagnosis or treatment of learning disabilities.
47. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
48. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
49. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

50. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
51. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
52. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
53. 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*.
54. For hearing aids, except as expressly provided in this *policy*.
55. 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.
56. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive *days*. If travel extends beyond 90 consecutive *days*, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 *days*.
57. 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.
58. For or related to treatment of hyperhidrosis (excessive sweating).
59. For fetal reduction surgery.
60. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
61. 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).
62. 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.

63. 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.
64. 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 section; routine foot care except when related to diabetes, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
65. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
66. For court ordered testing or care unless *medically necessary*.
67. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party. surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This *exclusion* applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.
68. For any medicinal and recreational use of cannabis or marijuana.

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

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

Termination

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

8. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
9. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request;
10. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
11. The date of *your* death, if this *policy* is an Individual Plan;
12. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes. If an HRA is offered, employer payments would be acceptable and exempt from the limitation;
13. 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
14. The date a *member's* eligibility for coverage under this *policy* ceases as determined by *us*.

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 written notice, delivered, or mailed to the Exchange, or if an off-exchange *member* by written notice, delivered, or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 *days*. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

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

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew 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 and refuse to renew 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.

Benefits After Coverage Terminates

Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

4. A request by *you*;
5. Fraud or material misrepresentation on *your* part; or
6. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*. The *period of extended loss* must begin before coverage of the *member* ceases under this *policy*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

3. The date the *continuous loss* ends; or
4. 12 months after the date renewal is declined.

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

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

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

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

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

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

12. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
13. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
14. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
15. To give Western Sky Community Care, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
16. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Western Sky Community Care, Inc. as reimbursement for

the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

17. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.
18. 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.
19. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement rights.
20. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
21. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
22. That *we* may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse *us*.

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

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

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

Coordination of Benefits

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

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

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

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

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

7. 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.
8. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
9. Plan includes *hospital*, medical, and surgical benefits coverage of *Medicare* or a governmental plan offered, required, or provided by law, except Medicaid.
10. 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.
11. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through *health maintenance organizations (HMO's)* or coverage under other prepayment, group practice and individual practice plans.
12. Plan whose benefits are by law excess to any private benefits coverage.

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

3. The plan has no order of benefits rules or its rules differ from those required by regulation; or
4. 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:

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

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

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

c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

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

Effects of Coordination

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

Right to Receive and Release Needed Information

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

Claims

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

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

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

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

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

To request reimbursement for a *covered service*, *you* need a copy of the detailed claim from *your provider*. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at Ambetter.WesternSkyCommunityCare.com under "Member Resources." Send all the documentation to *us* at the following address:

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

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

5. 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.
6. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
7. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
8. Furnish any other information, aid or assistance that *we* may require, including without *limitation*, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

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

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

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

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

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

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

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

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable *medical records* in English to show proper *proof of loss* and evidence of payment to the *provider*.

Assignment
We will reimburse a *hospital* or health care *provider* if:

3. *Your* health insurance benefits are assigned by *you* in writing; and
4. *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:

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

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

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

Upon request by the custodial parent, *we* will:

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

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

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

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

Summary of Health Insurance Grievance Procedures

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

3. Send a request in writing to Ambetter at:
   Ambetter from Western Sky Community Care, Inc.
   5300 Homestead Road NE
   Albuquerque, NM 87110
   Member Services: 1-833-945-2029 (TDD/TTY: 711)
   Fax: 1-833-886-7956
   Web address: Ambetter.WesternSkyCommunityCare.com
   Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

4. From the OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

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

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

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

Review of an Adverse Determination

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

Coverage: First, *we* determine whether the requested service is covered under the terms of your health benefits plan (*policy*). For example, if *your policy* excludes payment for adult hearing aids, then *we* will not agree to pay for *you* to have them even if *you* have a clear need for them.
Medical necessity: Next, if Ambetter finds that the requested service is covered by the *policy*, Ambetter determines, in consultation with a physician, whether a requested service is *medically necessary*. The consulting physician determines medical necessity either after consultation with *specialists* who are experts in the area or after application of uniform standards used by Ambetter. For example, if *you* have a crippling hand injury that could be corrected by plastic surgery and *you* are also requesting that Ambetter pay for cosmetic plastic surgery to give *you* a more attractive nose, Ambetter might certify the first request to repair *your* hand and deny the second, because it is not *medically necessary*.

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

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

How long does initial certification take?
Standard decision: Ambetter must make an initial decision within 5 working days. However, Ambetter may extend the review period for a maximum of 10 calendar days if it:

4. Can demonstrate reasonable cause beyond *our* control for the delay;
5. Can demonstrate that the delay will not result in increased medical risk to *you*; and
6. Provide a written progress report and explanation for the delay to *you* and *your provider* within the original 5 working day review period.

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

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

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

must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

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

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

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

When will I be notified that my initial request has been either certified or denied?
If the initial request is approved, Ambetter must notify *you* and *your provider* within 1 working day after the decision, unless an urgent matter requires a quicker notice. If Ambetter denies certification, Ambetter must notify *you* and the *provider* within 24 hours after the decision.

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

Telephone: 1-833-945-2029
Address: Ambetter from Western Sky Community Care Grievances and Appeals Department
12515-8 Research Blvd., Ste. 400
Austin, TX 78759
FAX #: 1-833-751-0895
Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:
Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674

Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

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

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

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

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

How Long a First Level Review Takes

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

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

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

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

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

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

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

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

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

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

If you choose to have your request reviewed by the Ambetter panel, can you still request the IRO review?

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

What's an IRO and what does it do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with Ambetter or with *you*. The reviewer will consider all of the information that is provided by Ambetter and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, Ambetter, and to OSI. Ambetter must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then Ambetter must provide them.
The IRO's fees are billed directly to Ambetter – there is no charge to you for this service.

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

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

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

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?
If *you* are dissatisfied with an initial administrative decision made by Ambetter, *you* have a right to request an internal review within **180 days** after the date *you* are notified of the decision. Ambetter will notify *you*

within 3 days after receiving *your* request for a review and will review the matter promptly. *You* may submit relevant information to be considered by the reviewer.

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

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

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

If you are unable to prepare for the committee hearing within the time set by Ambetter, you may request that the committee hearing be postponed for up to 30 days.
The reconsideration committee will mail its decision to you within 7 days after the hearing.

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

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

General Information

Confidentiality

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

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

Reporting requirements
Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. *You* may review the results of the annual reports on the OSI website.
The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

General Provisions

Entire Policy

This *policy,* with the application, is the entire *policy* between *you* and *us.* No agent may:

5. Change this *policy*;
6. Waive any of the provisions of this *policy*;
7. Extend the time for payment of premiums; or
8. Waive any of *our* rights or requirements.

Non-Waiver

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

Rescissions

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

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

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with State Laws

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

Personal Health Information

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

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPPA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like

the complete notice, please visit https://Ambetter.WesternSkyCommunityCare.com/privacy-practices.html or call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

We protect all of *your* PHI. *We* follow HIPPA to keep *your* healthcare information private.

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

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care , tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [Phone Number]

Navajo: Din4 k'ehj7 y1n7[ti'go ata' hane' n1 h0l= d00 naaltsoos t'11 Din4 k'ehj7 bee bik'e'ashch98go nich'8' 1dooln7i[go bee haz'3 a[d0' 1ko d77 t'11 1t'4 t'11 j77k'e k0t'4ego nich'8' 22'1t'4. Koj8' h0lne' [Phone Number]

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Western Sky Community Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi [Phone Number].

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer [PhoneNumber] an.

Chinese: 如果您，或是您正在協助的對象，有關於 Ambetter from Western Sky Community Care方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 [Phone Number]。

Arabic: إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Western Sky Community Care ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ [Phone Number].

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Western Sky Community Care에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [Phone Number] 로 전화하십시오.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa [Phone Number].

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

French: Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le [Phone Number]

Italian: Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Western Sky Community Care, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'[Phone Number].

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Western Sky Community Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону [Phone Number].

Hindi: आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Western Sky Community Care के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए [Phone Number] पर कॉल करें।

Persian: اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Western Sky Community Care دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره [Phone Number] تماس بگیرید.

Thai: หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข [Phone Number].

Statement of Non-Discrimination

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

Ambetter from Western Sky Community Care:

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

If you need these services, contact Ambetter from Western Sky Community Care at 1-833-945-2029 (TTY/TDD 711)

If you believe that Ambetter from Western Sky Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Western Sky Community Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
www.osi.state.nm.us

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

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

AMB20-NM-C-00189

Declaración de no discriminación

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

Ambetter from Western Sky Community Care:

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

Si necesita estos servicios, comuníquese con Ambetter from Western Sky Community Care a at 1-833-945-2029 (TTY/TDD 711)

Si considera que Ambetter from Western Sky Community Care no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo o fax. Si necesita ayuda para presentar una queja, Ambetter from Western Sky Community Care está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
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AMB20-NM-C-00189

ambetter. FROM western sky community care

2021 Evidence of Coverage

Ambetter.WesternSkyCommunityCare.com

Member Services Department: 1-833-945-2029 (TDD/TTY: 711)
Log on to: Ambetter.WesternSkyCommunityCare.com

Ambetter from Western Sky Community Care, Inc.

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

Major Medical Expense Insurance Policy

In this *policy,* the terms *"you"*, *"your",* or *"yours"* will refer to the *member* or any *dependents* named on the *Summary of Benefits and Coverage (SBC)*. The terms *"we," "our,"* or *"us"* will refer to Western Sky Community Care, Inc.

AGREEMENT AND CONSIDERATION

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

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

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

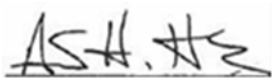
At least 60 *days'* notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *member's* health.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

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

TEN DAY RIGHT TO RETURN POLICY

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

Western Sky Community Care, Inc.



Antonio H. Hernandez
Plan President/CEO

TABLES OF CONTENTS

Introduction

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

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

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

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

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. MST
Member Services **1-833-945-2029**
TDD/TTY line **711**
Fax **1-833-751-0895**
Emergency **911**
24/7 Nurse Advice Line **1-855-604-1303** or for the hearing impaired (TDD/TTY 711)

Interpreter Services
Ambetter from Western Sky Community Care, Inc. 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. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

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

Member Rights and Responsibilities

We are committed to:

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

If *you* have difficulty locating a primary care provider, *specialist*, *hospital* or other contracted provider please contact us so that we can assist *you* with access or in locating a contracted Ambetter provider. Ambetter physicians may be affiliated with different hospitals. Our online directory can provide *you* with information on the Ambetter contracted hospitals. The online directory also lists affiliations that your provider may have with non-contracted hospitals. Your Ambetter coverage requires *you* to use contracted providers with limited *exceptions*.

You have the right to:

59. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
60. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
61. Receive the benefits for which *you* have coverage.
62. Have services available and accessible when *medically necessary*.
63. Have access to urgent and emergency care services 24 hours per day, seven days per week, and for other health care services as defined by the *policy*.
64. Be treated with courtesy and consideration, and with respect for the covered person's dignity and need for privacy.
65. Be provided with information concerning *our* policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
66. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
67. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
68. 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 practitioner* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care practitioner* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information

can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.

69. Make recommendations regarding *member's* rights, responsibilities, and policies.
70. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
71. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
72. See *your medical records*.
73. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care practitioner* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 *days* before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
74. Receive prompt notification of termination or changes in benefits, services or provider network.
75. A current list of *participating providers*.
76. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
77. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion.
78. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
79. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care practitioner's* instructions are not followed. *You* should discuss all concerns about treatment with *your primary care practitioner*. *Your primary care practitioner* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
80. A complete explanation of why care is denied.
81. An opportunity to appeal the denial decision to *us*, the right to a secondary appeal, and the right to request the superintendent's assistance.
82. Select *your primary care practitioner* within the *network*. *You* also have the right to change *your primary care practitioner* or request information on *participating providers* close to *your* home or work.
83. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your primary care practitioner*.
84. An interpreter when *you* do not speak or understand the language of the area.
85. A *second opinion* by a *network physician*, at no cost to *you*, if *you* believe your *participating provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
86. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
87. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care practitioner* 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:

33. Read this *policy* in its entirety.
34. Treat all health care professionals and staff with courtesy and respect.
35. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *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.
36. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
37. Show *your* ID 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.
38. Know the name of *your* assigned *primary care practitioner*. *You* should establish a relationship with *your physician*. *You* may change *your primary care practitioner* verbally or in writing by contacting *our* Member Services Department.
39. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
40. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
41. Supply, to the extent possible, information that *we* or *your* health care professionals and *physicians* need in order to provide care.
42. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
43. 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 practitioner* 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.
44. Follow all health benefit plan guidelines, provisions, policies, and procedures.
45. Use any *emergency* room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care practitioner*.
46. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
47. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost sharing percentages* at the time of service.
48. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 *days* from the date of the event.

Provider Directory

A listing of *participating providers* is available online at Ambetter.WesternSkyCommunityCare.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our participating 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, board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-833-945-2029 (TDD/TTY: 711). In order to obtain benefits, *you* must designate a *network primary care practitioner* for each *member. We* can also help *you* pick a *primary care practitioner* (*PCP*). *We* can make *your* choice of *primary care practitioner* effective on the next *business day*.

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

Member ID Card

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

The ID card will show *your* name, member ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-833-945-2029 (TDD/TTY: 711). *We* will send *you* another card.

Website

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

21. Finding a *participating provider*.
22. Locate other *providers* (e.g., *hospitals* and pharmacies)
23. *Our* programs and services, including programs to help *you* get and stay healthy.
24. A secure portal for *you* to check the status of *your* claims, make payments, and obtain a copy of *your* Member ID card.
25. Member Rights and Responsibilities.
26. Notice of Privacy Practices.
27. Current events and news.
28. *Our* Formulary or Preferred Drug List.
29. *Deductible* and *copayment* accumulators.
30. Selecting a *Primary Care Provider*.

Quality Improvement

We are committed to providing quality healthcare 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 Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

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

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

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 healthcare and services *you* are receiving.

Definitions

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

Wherever used in this *policy*:

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

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

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

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

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

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

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

Authorization or ***Authorized*** (also "*Prior Authorization*" or "*Approval*") means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or provider group.

Autism spectrum disorder means *autism spectrum disorder* as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases (ICD-10).

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

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

Complications of pregnancy means:

5. 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 complication of *pregnancy*.
6. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *policy*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to

the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

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

Cost sharing percentage means the percentage of *covered services* that are payable by *us*.

Covered service or ***covered service expenses*** means services, supplies, or treatment as described in this *policy* which are performed, prescribed, directed, or *authorized* by a *physician.* To be a *covered service* the service, supply, or treatment must be:

7. Provided or incurred while the *member's* coverage is in force under this *policy*;
8. Covered by a specific benefit provision of this *policy*; and
9. Not excluded anywhere in this *policy*.

Covered person means a subscriber, policyholder, or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

Custodial care is treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily *injury*.
Custodial care includes (but is not limited to) the following:

11. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding, and use of toilet;
12. Preparation and administration of special diets;
13. Supervision of the administration of medication by a caregiver;
14. Supervision of self-administration of medication; or
15. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care, or recreational care.

Such treatment is custodial regardless of who orders, prescribes, or provides the treatment.

Day or Days shall be interpreted as follows, unless otherwise specified:

(e) One to five *days* means only working *days* and excludes weekend and state holidays; and
(f) Six or more *days* means calendar *days*, including weekends and state holidays.

Deductible amount or ***Deductible*** means a fixed dollar amount that a *covered person* may be required to pay during a benefit period before the health insurance carrier begins payment for covered benefits; health benefit plans may have both individual and family *deductibles* and separate *deductibles* for specific services.

If *you* are a covered *member* in a family of two or more *members*, *you* will satisfy *your deductible amount* when:

5. *You* satisfy *your* individual *deductible amount*; or

6. *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 the *deductible* until the family *deductible amount* is satisfied for the *calendar year*.

Dental services 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 *your* lawful *spouse* or an *eligible child*.

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 *covered person*, if that child is less than 26 years of age. As used in this definition, "child" means:

11. A natural child;
12. A legally adopted child;
13. A child placed with *you* for adoption;
14. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
15. A stepchild.

It is *your* responsibility to notify Member Services if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible service expense means a *covered service expense* as determined below.

5. For *participating providers*: When a *covered service* is received from a *participating provider*, the *eligible service expense* is the contracted fee with that *provider*.
6. For *nonparticipating providers*:
    a. When a *covered service* is received from a *nonparticipating provider* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the greatest of the following:
        i. the amount that would be paid under *Medicare*,
        ii. the amount for the *covered service* calculated using the same method *we* generally use to determine payments for out-of-network services, or

iii. the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts.

Please note: *You* should not be balanced billed by the *provider*, if *you* are, please contact Member Services.

b. When a *covered service* is received from a *nonparticipating provider* as *approved* or *authorized* by *us* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*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 service expense* is the greater of (1) the amount that would be paid under *Medicare*, or (2) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.

c. When a *covered service* is received from a *nonparticipating provider* because the service or supply is not available from any *participating provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept 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 service expense* is the greater of (1) the amount that would be paid under *Medicare*, or (2) the contracted amount paid to *participating providers* for the *covered service*. If there is more than one contracted amount with *participating providers* for the *covered service*, the amount is the median of these amounts. *You* should not be balance billed by the *provider*, if *you* are, please contact Member Services.

d. Please note: In other circumstances, you may be balance billed if you knowingly choose to receive non-emergency care from a *nonparticipating provider*.

Emergency* (Medical, Behavioral Health, and Substance Use) *Services means covered *inpatient* and *outpatient services* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an *emergency* medical/behavioral health condition. An *emergency* medical/behavioral health medical 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:

9. Placing the physical or behavioral health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
10. Serious impairment to bodily functions;
11. Serious dysfunction of any bodily organ or part;
12. Serious harm to self or others due to an alcohol or drug use emergency; *Injury* to self or bodily harm to others; or with respect to a pregnant woman having contractions: (1) that there is inadequate

time to effect a safe transfer to another *hospital* before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Follow-up care is not considered emergency care. Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include *facility* costs and *physician* services, and supplies and *prescription drugs* charged by that *facility*. If *you* are admitted into the *hospital*, *we* require notification of *your hospital* admission. When *we* are contacted, *you* will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting *us*, *you* may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under *your* Plan. If *your provider* does not contract with *us*, *you* will be financially responsible for any care *we* determine is not *medically necessary*. Care and treatment provided once *you* are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a *nonparticipating provider* beyond that needed to evaluate or *stabilize your* condition in an *emergency* will be covered as a non-*network* service unless *we authorize* the continuation of care and it is *medically necessary*.

Emergency care means health care procedures, treatments or services delivered to a *covered person* after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, *emergency* services, hospitalization, maternity and newborn care, mental health and *substance use disorder* services, including behavioral health treatment, *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this *policy* are not subject to lifetime or annual dollar maximums. Certain non-*essential health benefits*, however, are subject to either a lifetime or annual dollar maximum.

Expedited grievance means a *grievance* where any of the following applies:

7. 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.
8. 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*.
9. A *physician* with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental or ***investigational treatment*** 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:

9. 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 *USFDA* oversight.
10. An *unproven service.*
11. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
12. *Experimental* or *investigational* according to the *provider's* research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise *covered services* under this *policy*.

Extended care facility means an institution, or a distinct part of an institution, that:
13. Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
14. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
15. Maintains a daily record on each patient;
16. Has an effective *utilization review* plan;
17. Provides each patient with a planned program of observation prescribed by a *physician;* and
18. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

Facility means an entity providing health care service, including:
s. A general, specialized, psychiatric or rehabilitation *hospital*;
t. An *ambulatory surgical center*;
u. A cancer treatment center;
v. A birth center;
w. An impatient, outpatient or residential drug and alcohol treatment center;

x. A laboratory, diagnostic or other outpatient medical evaluation or testing center;
y. A health care *provider's* office or clinic;
z. An *urgent care center*; or
aa. Any other therapeutic health care setting.

Generally accepted standards of medical practice are 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 any dissatisfaction with 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 including any of the following:
9. Provision of services.
10. Determination to rescind a *policy*.
11. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*.
12. Claims practices.

Habilitation or ***habilitation services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or outpatient settings.

Health maintenance organization (HMO) a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care exempt in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Management means a program designed specially to assist *you* in managing a specific or chronic health condition.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *member.*

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is:
5. Provided by a *home health care agency*; and

6. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:

9. Operates pursuant to law as a *home health care agency*;
10. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
11. Maintains a daily *medical record* on each patient; and
12. 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 refers to services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by an Ambetter physician. Ambetter works with certified hospice programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of terminally ill *members* and their *immediate family*.

Hospital means a *facility* offering impatient services, nursing and overnight care for three or more individuals on a 24-hours-per-*day*, seven-*days*-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

Illness means a sickness, disease, or disorder of a *member*. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, *eligible child*, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that services, supplies, or treatment for medical, behavioral health, or *substance abuse* 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 Cardiac Care Unit, or other unit or area of a *hospital* that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Limitation means any provision that restricts coverage under a health benefits plan other than an *exception*, *exclusion* or *reduction*.

Listed transplant means one of the following procedures and no others:

13. Heart transplants.
14. Lung transplants.
15. Heart/lung transplants.
16. Kidney transplants.
17. Liver transplants.
18. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile.

Loss means an event for which benefits are payable under this *policy*. A *loss* must occur while the *member* is covered under this *policy*.

Loss of minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

15. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
16. In the case of coverage offered through an *HMO*, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual);
17. In the case of coverage offered through an *HMO*, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of

coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual), and no other benefit package is available to the individual;

18. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
19. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual;
20. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
21. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance* percentage of *covered expenses*, as shown in the *Summary of Benefits and Coverage (SBC)*. After the *maximum out-of-pocket amount* is met for an individual, Western Sky Community Care, Inc. pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Summary of Benefits and Coverage (SBC)*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any *covered persons' eligible service expenses*. A *covered person's maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket amount*.

If *you* are a covered *member* in a family of two or more *members*, *you* will satisfy *your maximum out-of-pocket* when:

5. *You* satisfy *your* individual *maximum out-of-pocket*; or
6. *Your* family satisfies the family *maximum out-of-pocket amount* for the *calendar year*.

If *you* satisfy *your* individual *maximum out-of-pocket*, *you* will not pay any more *cost sharing* for the remainder of the *calendar year*, but any other eligible *members* in *your* family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the *calendar year*.

The dental out-of-pocket maximum limits do not apply to the satisfaction of the *maximum out-of-pocket* per *calendar year* as shown in the *Summary of Benefits and Coverage (SBC)*.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medical record means all information maintained by a *provider* relating to the past, present or future physical or behavioral health of a patient, and for other provision of health care services to a patient. This information includes, but is not limited to the *provider's* notes, reports and summaries, and x-rays, laboratory, and other diagnostic test results. A patient's complete *medical record* includes information generated and maintained by the *provider*, as well as other information provided to the *provider* by the patient, by any other *provider* who has consulted with or treated the patient in connection with the provision of health care services to the patient. A *medical record* does not include the patient's medical billing or health insurance records or forms or communications related thereto.

Medically necessary means health care services determined by a *provider*, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

g. any applicable generally accepted principles and practices of good medical care;
h. practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
i. any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, *illness*, *injury* or disease.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Medicare means Title 18 of the Social Security Amendments of 1965, "Health Insurance for Aged and Disabled," as then constituted or later amended.

Medicare opt-out practitioner means a *medical practitioner* who:

5. Has filed an affidavit with the Department of Health and Human Services stating that he or she will not submit any claims to *Medicare* during a two-year period; and
6. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from *Medicare* for treating *Medicare*-eligible individuals.

Member means an individual covered by the health plan including an enrollee, subscriber, or policyholder.

Mental disorder means a behavioral, emotional, or cognitive disorder that is listed in the most recent edition of the International Classification of Diseases.

Necessary medical supplies means medical supplies that are:

7. Necessary to the care or treatment of an *injury* or *illness*;
8. Not reusable or *durable medical equipment*; and
9. 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 the group or groups of *participating providers* who provide health care services under a network plan.

Network eligible service expense means the *eligible service expense* for services or supplies that are provided by a *participating provider*. For *facility* services, this is the *eligible service expense* that is provided at and billed by a *network facility* for the services of either a *network* or *nonparticipating provider*. *Network eligible service expense* includes benefits for *emergency* health services even if provided by a *nonparticipating provider*.

Non-elective caesarean section means:

5. A caesarean section where vaginal delivery is not a medically viable option; or
6. A repeat caesarean section.

Nonparticipating provider means a *provider* who is not a *participating provider* as defined. Also known as an out-of-*network provider* or non-contracted *provider*.

Orthotic device means a *medically necessary* custom fabricated brace or support that is designed as a component of a *prosthetic device*.

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, *health maintenance organization* subscriber contracts, self-insured group plans, prepayment plans, and *Medicare* when the *member* is enrolled in *Medicare*. *Other plan* will not include Medicaid.

Outpatient services include both *facility*, ancillary, *facility* use, and professional charges when given as an outpatient at a *hospital*, alternative care *facility*, retail health clinic, or other *provider* as determined by the plan. These *facilities* may include a non-*hospital* site providing diagnostic and therapy services, *surgery*, or

rehabilitation, or other *provider facility* as determined by *us*. Professional charges only include services billed by a *physician* or other professional.

Outpatient surgical facility means any *facility* with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Participating provider means a *provider* who, under an express contract with a health insurance carrier or with its contractor or subcontractor, has agreed to provide health care services to *covered persons* with an expectation of receiving payment directly or indirectly from the carrier, subject to any cost-sharing required by the health benefits plan. Also known as in-*network* provider or contracted provider.

Period of extended loss means a period of consecutive days:

5. Beginning with the first *day* on which a *member* is a *hospital inpatient;* and
6. Ending with the 30th consecutive *day* for which he or she is not a *hospital inpatient.*

Physician means a licensed *medical practitioner* who is practicing within the scope of his or her licensed authority in treating a bodily *injury* or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage, or adoption or who is normally a member of the *covered person's* household.

Policy when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Post-service claim means a claim submitted to a health insurance carrier by or on behalf of a *covered person* after health care services have been provided to the *covered person*.

Practitioner of the healing arts means a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

11. the Chiropractic Physician Practice Act
12. the Dental Health Care Act
13. the Medical Practice Act
14. Chapter 61, Article 10 NMSA 1978; and
15. The Acupuncture and Oriental Medicine Practice Act

Note: *Practitioner of the healing arts* could be a *primary care practitioner (PCP)*

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the claimant obtaining the medical care.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered expenses*, shown in the *Summary of Benefits and Coverage (SBC)*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *covered persons' eligible service expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each *authorized* refill or such requests.

Preventive care means health care services provided for prevention and early detection of disease, *illness*, *injury* or other health condition.

Primary care practitioner (***PCP*****)** means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to *covered persons*; who initiates the patient's referral for *specialist* care and who maintains continuity of patient care. *Primary care practitioners* include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other health care professionals (such as *Practitioner of the healing arts*) may also serve as *primary care practitioners*.

Prior Authorization means a pre-service determination made by a health insurance carrier regarding a *covered person's* eligibility for health care services based on medical necessity, health benefits coverage and the appropriateness and a site of services pursuant to the terms of the health benefits plan.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It may include, but is not limited to, claim forms, medical bills or records, *other plan* information, payment of claim, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including *Medicare*.

Prosthetic device means an artificial leg or arm.

Provider means a licensed health care professional, *hospital* or other *facility authorized* to furnish health care services.

Provider facility means a *hospital, rehabilitation facility*, or *extended care facility*.

Qualified health plan or ***QHP*** means a major medical plan that has been reviewed and deemed by the superintendent to provide *essential health benefits*, follow established limits on cost-sharing, provide "minimum essential coverage" and meet the other requirements of the Affordable Care Act.

Reconstructive surgery means *surgery* from which an improvement in physiological function could reasonably be expected, when ordered by a *member's* primary care practitioner or treating health care professional and performed for the correction of functional disorders resulting from accidental *injury* or from congenital defects or disease.

Rehabilitation means health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical or occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

5. Is licensed by the state as a *rehabilitation facility*; and
6. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a *facility* primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

Rehabilitation licensed practitioner means, but is not limited to, a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

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:

5. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
6. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Respite care means *home health care* services provided temporarily to a *member* in order to provide relief to the *member's immediate family* or other caregiver.

Second opinion means an opportunity or requirement for a *covered person* to obtain a clinical evaluation to assess the medical necessity and appropriateness of the initial proposed health service, by a *provider* other than one who originally recommended or denied it.

Service Area means a geographical area, made up of counties, where *we* have been *authorized* by the State of New Mexico to sell and market *our* health plans. This is where the majority of *our participating providers* are located where *you* will receive all of *your* health care services and supplies. *You* can receive precise *service area* boundaries from *our* website or *our* Member Services department.

Social Determinants of Health are the circumstances in which people are born, grow up, live, work, and age. This also includes the systems in place to offer health care and services to a community.

Specialist physician means a *physician* who is not a *primary care practitioner.*

Specialist or Specialist provider means a *physician* or non-physician health care professional who:

(e) focuses on a specified area of physical or behavioral health or specific group of patients; and
(f) Has successfully completed required training and is recognized by the state in which the health care professional practices to provide specialty care.

Spouse means *your* lawful wife or husband.

Stabilize means to provide physical or behavioral health treatment of a condition as may be necessary to ensure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a *facility* or, with respect to an *emergency* birth with no complications resulting in a continuing *emergency*, to deliver the child and the placenta.

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance use disorders* are those listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases (ICD-10).

Summary of Benefits and Coverage (SBC) means a comprehensive listing of *covered services* and applicable *cost sharing*.

Surgery or ***surgical procedure*** means:

5. An invasive diagnostic procedure; or
6. The treatment of a *member's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *member* is under general or local anesthesia.

Surprise bill reimbursement rate means the sixtieth (16th) percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit

organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill reimbursement rate shall be paid at less than one hundred fifty percent (150%) of the 2017 Medicare reimbursement rate for the applicable health care service provided.

Surrogate means an individual who, as part of a *surrogacy arrangement*, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in her body but the egg is not her own.

Surrogacy Arrangement means an understanding in which a woman (the *surrogate*) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the *surrogate* receives payment for acting as a *surrogate*.

Surveillance tests for ovarian cancer means annual screening using:

7. CA-125 serum tumor marker testing;
8. Transvaginal ultrasound; or
9. Pelvic examination.

Telehealth means the use by a health care professional of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that a *member* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term *third party* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *third party* will not include any insurance company with a policy under which the *member* is entitled to benefits as a named insured person or an insured *dependent member* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco or nicotine use or ***use of tobacco or nicotine*** means *use of tobacco or nicotine* by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *policy* was completed by the *member*, including all tobacco and nicotine products, e-cigarettes or vaping devices, but excluding religious and ceremonial uses of tobacco.

Transcranial Magnetic Stimulation (TMS) is a non-invasive procedure in which a changing magnetic field is used to cause electric current to flow in a small targeted region of the brain via electromagnetic induction.

Unproven service(s) means services, including medications, that are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

5. *"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.
6. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care means medically necessary health care services provided in emergencies or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Urgent care center means a *facility*, not including a *hospital* emergency room or a *physician's* office, that provides treatment or services that are required:

5. To prevent serious deterioration of a *member's* health; and
6. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

Urgent care situation means a situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

11. The life or health of the covered person would otherwise be jeopardized;
12. The covered person's ability to regain maximum function would otherwise be jeopardized;
13. In the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or treatment;
14. The medical exigencies of the case require expedited care; or
15. The covered person's claim otherwise involves urgent care.

Utilization review means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

Enrollment and Eligibility

An individual must be enrolled as a *member* under this *policy* for *covered services* to be available. To enroll and become a *member*, an individual must:

6. Live or work in the Service Area, as determined by Ambetter;
7. Not be incarcerated, other than incarceration pending disposition of charges;
8. Not be eligible for *Medicare* due to age, illness, or disability;
9. Apply during an open enrollment period or within 60 days of a qualifying event as described in Special and Limited Enrollment section of this *policy*; and
10. Pay the premium due prior to the coverage *effective date*.

Note: *Members* who are Ending Stage Renal Disease (ESRD) patients have the choice of whether to enroll in *Medicare* or retain commercial coverage despite their eligibility for *Medicare*.

Dependent Member Coverage

Dependent Member Eligibility

Your dependent members become eligible for insurance on the latter of:

13. The date *you* became covered under this *policy;*
14. The date of marriage to add a *spouse*;
15. The date of an eligible newborn's birth; or
16. 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.
17. The date you are required by a court order or administrative order to provide coverage for an eligible child; or
18. The date you are required to provide coverage for a dependent student due to medically necessary leave of absence.

Effective Date for Initial Dependent Members

The *effective date* for *your* initial *dependent members,* if any, is shown on the *Summary of Benefits and Coverage (SBC)*. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Coverage for a Newborn Child

An *eligible child* born to *you* or a covered family member *will* be covered from the time of birth until the 31st *day* after its birth, unless we have received notice from you. An *eligible child* will be covered until the 31st *day* after its birth regardless whether notification is provided, but failure to provide such notification will prevent the child from being covered afterwards. Each type of covered service incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Summary of Benefits and Coverage (SBC)*.

Covered services for a newborn child include:

11. *Injury* or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care facility for newly born infants
12. Newborn visits in the *hospital* by the newborn's *primary care practitioner*

13. Circumcision for newborn males
14. Coverage for incubator
15. Routine *hospital* nursey charges

Additional premium will be required to continue coverage beyond the 31st *day* after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* within the 31 *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 within 60 *days* of the birth of the child, the *policy* 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 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. 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 within 60 *days* of the birth or placement and (B) any additional premium required for the addition of the child within 90 *days* of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:
5. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
6. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Coverage for a Child Born Out of Wedlock
We will not deny enrollment of a child if the child's parent is covered under this *policy* on the grounds that:
7. The child was born out of wedlock;
8. The child is not claimed as a dependent on the parent's federal tax return; or
9. The child does not reside with the parent or does not reside in *our service area*.

Coverage for a Child with Coverage through Insurance of Noncustodial Parent
When a child has coverage through an insurer of a noncustodial parent, *we* shall:
7. Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;
8. Permit the custodial parent or the *provider*, with the custodial parent's approval, to submit claims for *covered services* without the approval of the noncustodial parent; and

9. Make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the provider or the state Medicaid agency.

Court Order to Provide Child Coverage

When *you* are required by a court order or an administrative order to provide coverage for an *eligible child* *we* shall:

7. Permit the eligible parent to enroll, under the family coverage under this *policy*, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
8. If the eligible parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and
9. Not disenroll or eliminate coverage of the child unless *we* are provided satisfactory written evidence that:
    a. The court or administrative order is no longer in effect.

Adding Other Dependent Members

If *you* are enrolled in an off-exchange policy and apply in writing 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 ID cards for the added *dependent*.

Ongoing Eligibility

For All Members

A *member's* eligibility for coverage under this *policy* will cease on the earlier of:

15. 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*;
16. The date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
17. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
18. The date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request;
19. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this contract or the date that *we* have not received timely premium payments in accordance with the terms of this contract;
20. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g. the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract); or
21. The date of a *member's* death.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member* due to divorce or if a child ceases to be an *eligible child.* For *eligible children*, the coverage will terminate the thirty-first of December the year the dependent turns 26 years of age. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

A *member* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

5. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
6. Mainly dependent on *you* for support.

Open Enrollment

Each year there will be an open enrollment period for coverage. The open enrollment period begins November 1, 2020 and extends through December 15, 2020. Qualified individuals who enroll on or before December 15, 2020 will have an *effective date* of coverage on January 1, 2021.

Special and Limited Enrollment

A *qualified individual* has 60 *days* to report a qualifying event directly to *us* and could be granted a 60 *day* Special Enrollment Period as a result of one of the following events:

34. A *qualified individual* or *dependent loses minimum essential coverage,* non-*calendar year* group or individual health insurance coverage, *pregnancy*-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;

35. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order;
36. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
37. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
38. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer or employee, or its instrumentalities as evaluated and are determined by *us*. In such cases, *we* may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
39. An enrollee adequately demonstrates to *us* that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its policy in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
40. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a chance in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
41. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
42. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
43. 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;
44. A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA);
45. An enrollee loses access to their Marketplace plan as a result of death;
46. An enrollee loses access to their Marketplace plan as a result of divorce or legal separation;
47. Current employer plan no longer considered qualifying employer coverage;
48. An enrollee loses eligibility for Medicaid, Medicare or CHIP; or
49. An enrollee is a survivor of domestic violence, abuse or spousal abandonment.

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 ten (10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing

Ambetter requires each policyholder to pay his or her premiums and this is communicated on *your* monthly billing statements. Ambetter payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party premiums. Consistent with CMS guidance, the following are the only acceptable third parties who may pay Ambetter premiums on *your* behalf:

9. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
10. Indian tribes, tribal organizations, or urban Indian organizations;
11. State and Federal government programs; or
12. Family members.

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 subscription charges remain due.

Similarly, if we determine payment was made for *deductibles* or *cost sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a third party premium payment that may not be counted towards your *deductible* or maximum-out-of-pocket costs.

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 *days* of the change. As a result *your* premium may change and *you* may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco or Nicotine Use
The answer to the tobacco or nicotine question on the application is material to *our* correct underwriting. If a *member's use of tobacco or nicotine* has been misstated on the *member's* application for coverage under this *policy, we* have the right to rerate the *policy* back to the original *effective date*.

Prior Authorization

Ambetter reviews services to ensure the care *you* receive is the best way to help improve *your* health condition. Utilization review includes:

- Pre-service or *prior authorization* review – occurs when a medical service has been pre-approved by Ambetter
- Concurrent review – occurs when a medical service is reviewed as they happen (e.g., inpatient stay or hospital admission)
- Retrospective review – occurs after a service has already been provided.

Prior Authorization Required

Some *covered service expenses* require *prior authorization*. In general, *participating providers* must obtain *authorization* from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the *prior authorization*.

For services or supplies that require *prior authorization*, as shown on the *Summary of Benefits and Coverage (SBC)*, *you* must obtain *authorization* from *us* before *you* or *your dependent member:*

5. Receive a service or supply from a *nonparticipating provider;* or
6. Receive a service or supply from a *participating provider* to which *you* or *your dependent member* were referred to by a *nonparticipating provider.*

Prior authorization must be obtained for services or supplies after *you* or a *dependent member* are admitted into a network facility by a *nonparticipating provider* once emergency room transfer or *urgent care* stabilization has occurred.

Prior Authorization requests must be received by phone/efax/ Provider portal as follows:

11. At least 7 *days* prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* facility.
12. At least 7 *days* prior to the initial evaluation for organ transplant services.
13. At least 7 *days* prior to receiving clinical trial services.
14. Within 24 hours of an admission for *inpatient* mental health or *substance abuse* treatment.
15. At least 7 *days* prior to the start of *home health care*.

After *prior authorization* has been requested and all required or applicable documentation has been submitted, *we* will notify *you* and *your provider* if the request has been *approved* as follows:

11. For immediate request situations, within 1 *business day*, when the lack of treatment may result in an emergency room visit or *emergency* admission.
12. For urgent concurrent reviews within 24 hours of receipt of the request.
13. For urgent *pre-service* reviews, within 72 hours from date of receipt of request.
14. For non-urgent *pre-service* reviews within 5 *days*, but no longer than 15 *days*, of receipt of the request.
15. For post-service or retrospective reviews, within 30 calendar *days* of receipt of the request.

How to Obtain Prior Authorization
To obtain *prior authorization* or to confirm that a *participating provider* has obtained *prior authorization*, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member.*

Failure to Obtain Prior Authorization
Failure to comply with the *prior authorization* requirements may result in denial of payment.

Participating providers cannot bill *you* for services for which they fail to obtain *prior authorization* as required.

Benefits will not be reduced for failure to comply with *prior authorization* requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Services from Non-Network/Nonparticipating Providers
Except for *emergency* medical services, we do not normally cover services received from *nonparticipating providers*. If a situation arises where a *covered service* cannot be obtained from a *participating provider* located within a reasonable distance, we may provide *prior authorization* for *you* to obtain services from a *nonparticipating provider* at no greater cost to *you* than if *you* went to a *participating provider*. If *covered service*s are not available from a *participating provider, you* or your primary care provider must request *prior authorization* from *us* before *you* may receive services from a *nonparticipating provider*.

Services Requiring Prior Authorization
75. Adult Accidental Dental
76. Bariatric Surgery Inpatient
77. Bone Anchored Hearing Aids
78. Cardiac Rehabilitation
79. Cochlear Implants
80. Corrective Footwear Orthotics Shoes Inserts
81. Delin Inpatient Services Maternity Care
82. Diabetic Footwear
83. Diabetic Footwear Orthotics
84. Durable Medical Equipment
85. Hearing Aid Supplies Batteries
86. Home Healthcare
87. Imaging
88. Infertility Diagnostic Testing
89. Inherited Metabolic Disorder
90. Inpatient Facility Admission
91. Inpatient Mental Health
92. Inpatient Rehabilitation
93. Inpatient Substance Use
94. Mastectomy Bra

95. Neurodevelopmental Therapy
96. Neurological Rehabilitation
97. Outpatient Rehabilitation
98. Outpatient Substance Use
99. Outpatient Surgery Doctor
100. Outpatient Surgery Facility
101. Private Duty Nursing
102. Respite Care
103. Rx Preferred Drug
104. Rx Specialty Drug
105. Rx Specialty Mail Drug
106. Specialist Visit
107. Skilled Nursing Facility
108. Sleep Study
109. TMJ Treatment
110. Transplant
111. Wigs

Cost Sharing Features

Cost Sharing Features

We will pay benefits for *covered services* as described in the *Summary of Benefits of Coverage (SBC)* and the Covered Services sections of this Contract. All benefits *we* pay will be subject to all conditions, *limitations*, and *cost sharing* features of this Contract. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, *you* may need to pay a *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 Summary of Benefits of Coverage (SBC)*.

When you, or a covered dependent, receive health care services from a *provider*, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care *facility* or *provider* to treat a condition or an *illness*. Each claim that we receive for services covered under this contract are adjudicated or processed as we receive them. Coverage is only provided for *eligible service expenses*. Each claim received will be processed separately according to the cost share as outlined in the contract and in your *Summary of Benefits of Coverage (SBC)*.

Copayments

A *copayment* is typically a fixed amount due at the time of service. *Members* may be required to pay *copayments* to a *provider* each time services are performed that require a *copayment. Copayments* are due as shown in the *Summary of Benefits of Coverage (SBC)*. Payment of a *copayment* does not exclude the possibility of a *provider* billing *you* for any non-covered services. *Copayments* do not count or apply toward the *deductible amount*, but do apply toward your *maximum out-of-pocket amount*.

Coinsurance Percentage

A *coinsurance* amount is your share of the cost of a service. *Members* may be required to pay a *coinsurance* in addition to any applicable *deductible amount*(s) for a *covered service* or supply. *Coinsurance* amounts do not apply toward the *deductible*, but do apply toward your *maximum out-of-pocket amount*. When the annual *maximum out-of-pocket* has been met, additional *covered service expenses* will be 100%.

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amoun*t does not include any *copayment amount* or *coinsurance* amount. Not all *covered service expenses* are subject to the *deductible amount*. See *your Summary of Benefits of Coverage (SBC)* for more details.

Refer to your Summary of Benefits and Coverage (SBC) for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

5. Any specific benefit limits stated in the *policy*; and
6. A determination of *eligible service expenses*.

The applicable *deductible amount(s), cost sharing percentage,* and *copayment amounts* are shown on the *Summary of Benefit and Coverage (SBC)*.

Note: The bill *you* receive for services or supplies from a *nonparticipating provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing percentage*, *you* are responsible for the difference between the *eligible service expense* and the amount the *nonparticipating provider* bills *you* for the services or supplies. Any amount *you* are obligated to pay to the *nonparticipating provider* in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

Access to Care

Primary Care Provider

In order to obtain benefits, *you* must designate a *network primary care practitioner* for each *member.* If *you* do not select a *network primary care provider* for each member, one will be assigned. *You* may select any *network primary care practitioner* who is accepting new patients from any of the following *provider* types:

- Family practitioners
- General practitioners
- Internal medicine
- Nurse practitioners*
- Physician assistants
- Obstetricians/gynecologists
- Pediatricians (for children)

*If *you* choose a nurse practitioner as your PCP, *your* benefit coverage and *copayment amounts* are the same as they would be services from other in-network *providers*. See *your Summary of Benefits* for more information.

Any female *member* age 13 or older may designate an OB/GYN as a *network primary care practitioner*. *You* may obtain a list of *network primary care practitioners* at *our* website and using the "Find a Provider" function or by contacting *our* Member Services department.

You should get to know your PCP and establish a health relationship with them. *Your* PCP will:

- Provide preventive care and screenings
- Conduct regular physical exams as needed
- Conduct regular immunizations as needed
- Deliver timely service
- Work with other doctors when *you* receive care somewhere else
- Coordinate specialty care with Ambetter in-network specialists
- Provide any ongoing care *you* need
- Update *your* medical record, which includes keeping track of all the care that *you* get from all of *your providers*
- Treat all patients the same way with dignity and respect
- Make sure *you* can contact him/her or another provider at all times
- Discuss what advance directive are and file directives appropriately in *your* medical record.

Your network primary care practitioner will be responsible for coordinating all covered health services and making referrals for services from other *participating providers. You* may be required to obtain a referral from a *primary care provider* in order to receive care from a *specialist provider*. *You* do not need a referral from *your network primary care practitioner* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. *Prior authorization* will not be required for gynecological or obstetrical ultrasounds.

Changing Your Primary Care Practitioner

You may change *your network primary care practitioner* by submitting a written request, online at *our* website, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care practitioner* of record will be effective no later than 30 *days* from the date *we* receive *your* request.

Contacting Your Primary Care Practitioner
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. At every appointment, make sure *you* bring *your member* ID card and a photo ID.

Should *you* need care outside of *your* PCP's office hours, *you* should call *your* PCP's office for information on receiving after hours care in your area. If *you* have an urgent medical problem or question or cannot reach *your* PCP during normal office hours, call *our* 24/7 nurse advice line at 1-877-687-1180 (TTY/TDD 1-877-941-9231). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care practitioner* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care practitioner* for benefits to be payable under *your policy* or benefits payable under this *policy* may be reduced. Please refer to the *Summary of Benefit and Coverage (SBC)*.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *participating providers*. *You* will be notified of any increase in premium.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *policy.*

Non-Emergency Services
If you are traveling outside of the New Mexico service area *you* may be able to access providers in another state. *You* can locate Ambetter providers outside of New Mexico by searching the relevant state in our directory at ProviderSearch.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* ID card for further information.

Emergency Services Outside of Service Area
We cover emergency care services when *you* are outside of *our* service area.

If *you* are temporarily out of the service area and have a medical or behavioral health emergency, call 911 or go to the nearest emergency room. Be sure to call *us* and report *your* emergency within one business day. *You* do not need prior approval for emergency care services.

New Technology

Health technology is always changing. If *we* think a new medical advancement can benefit *our* members, *we* evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Sometimes, *our* medical director and/or medical management staff will identify technological advances that could benefit *our* members. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether *we* should change any of *our* benefits to include the new technology.

If the CPC does not review a request for coverage of new technology, *our* Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request a future meeting.

Major Medical Expense Benefits

Ambulance Service Benefits

Covered service expenses will include *ambulance services* for local transportation:

9. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
10. Transportation, including air transport, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest tertiary care *facility*.
11. 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.
12. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by *us*.

Benefits for air *ambulance services* are limited to:

5. Services requested by police or medical authorities at the site of an *emergency*.
6. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

11. Expenses incurred for *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
12. Non-*emergency* air ambulance.
13. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
14. *Ambulance services* provided for a *member's* comfort or convenience.
15. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Autism Spectrum Disorder Benefits

Generally recognized services prescribed in relation to *autism spectrum disorder* by a *physician* or behavioral health practitioner in a treatment plan recommended by that *physician* or behavioral health practitioner.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- *applied behavior analysis*;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy;
- *habilitation* services with a diagnosis of *autism spectrum disorder*; or

- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Coronavirus; COVID-19 Public Health Emergency

Coverage includes testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency as long as the public health emergency remains in effect, either declared by the state of New Mexico or federal government.
There is *no member cost sharing* requirements for testing and/or delivery of healthcare services that are related to COVID-19.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, diabetes education when received from a *medical practitioner*/*provider* who is approved to provide diabetes education; exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
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.

Insulin: The total amount you will be required to pay for a covered insulin medication will not exceed $25 per 30-day supply. If your cost share per 30-day supply of insulin medications is less than $25, you will be responsible for the lower amount. Please refer to our formulary for tier placement of insulin medications and your *Summary of Benefits and Coverage (SBC)* for your cost share responsibility for the associated drug tier.

Durable Medical Equipment, Prosthetics, and Orthotic Devices

The supplies, equipment, and appliances described below are *covered services* under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in *your* situation or needed to treat *your* condition, reimbursement will be based on the maximum allowable amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a *covered service* is *your* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates *your* condition. Repair, adjustment, and replacement of purchased equipment, supplies, or appliances as set forth below may be covered, as *approved* by *us*. The repair, adjustment, or replacement of the purchased equipment, supply, or appliance is covered if:

- The equipment, supply, or appliance is a *covered service*;
- The continued use of the item is *medically necessary*; and
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is

not reasonable justification).

In addition, replacement of purchased equipment, supplies, or appliance may be covered if:

9. The equipment, supply, or appliance is worn out or no longer functions.
10. Repair is not possible or would equal or exceed the cost of replacement. An assessment by *our* habilitation equipment specialist or vendor should be done to estimate the cost of repair.
11. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
12. The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage, or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment, or appliance described below.

Durable Medical Equipment

The rental (or, at *our* option, the purchase) of *durable medical equipment* prescribed by a *physician* or other *provider*. *Durable medical equipment* is equipment which can withstand repeated use; i.e. could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of *illness* or *injury*; and is appropriate for use in a patient's home. Examples include, but are not limited to, wheelchairs, crutches, *hospital* beds, and oxygen equipment. Rental cost must not be more than the purchase price. *We* will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services and supplies may include, but are not limited to:

17. Hemodialysis equipment.
18. Crutches and replacement of pads and tips.
19. Pressure machines.
20. Infusion pump for IV fluids and medicine.
21. Glucometer.
22. Tracheotomy tube.
23. Cardiac, neonatal, and sleep apnea monitors.
24. Augmentive communication devices are covered when *we approve* based on the *member's* condition.

Exclusions:

Non-covered items may include, but are not limited to:

15. Air conditioners.
16. Ice bags/coldpack pump.

17. Raised toilet seats.
18. Rental of equipment if the *member* is in a *facility* that is expected to provide such equipment.
19. Translift chairs.
20. Treadmill exerciser.
21. Tub chair used in shower.

See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.

Medical and surgical supplies

Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

Covered services and supplies may include, but are not limited to:

11. Allergy serum extracts.
12. Chem strips, Glucometer, Lancets.
13. Clinitest.
14. Needles/syringes.
15. 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:

15. Adhesive tape, band aids, cotton tipped applicators.
16. Arch supports.
17. Doughnut cushions.
18. Hot packs, ice bags.
19. Vitamins (except as provided for under Preventive benefits).
20. Medijectors.
21. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Orthotic devices

Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage, and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered *orthotic devices* and supplies may include, but are not limited to, the following:

19. Cervical collars.
20. Ankle foot orthosis.
21. Corsets (back and special surgical).
22. Splints (extremity).
23. Trusses and supports.
24. Slings.
25. Wristlets.

26. Built-up shoe.
27. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per *member* when *medically necessary* in the *member's* situation. However, additional replacements will be allowed for *members* under age 18 due to rapid growth, or for any *member* when an appliance is damaged and cannot be repaired.

*Exclusion*s:
Non-*covered services* and supplies include, but are not limited to:

9. Orthopedic shoes (except therapeutic shoes for diabetics).
10. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
11. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted (except as specified under Medical Supplies).
12. Garter belts or similar devices.

<u>Prosthetics</u>
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:

5. Replace all or part of a missing body part and its adjoining tissues; or
6. 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:

17. 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.
18. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
19. 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.
20. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
21. 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.

22. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
23. Restoration prosthesis (composite facial prosthesis).
24. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

*Exclusion*s:

Non-covered prosthetic appliances include, but are not limited to:

11. Dentures, replacing teeth, or structures directly supporting teeth.
12. Dental appliances.
13. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
14. Wigs (except as described above following cancer treatment).
15. Penile prosthesis in adults suffering impotency resulting from disease or *injury*.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

Covered service expenses include outpatient *facility* fees and services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following *limitations*:

11. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
12. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 *days* of a *hospital* stay of at least 3 consecutive *days* and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
13. *Covered service expenses* 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 U.S. Food and Drug Administration.
14. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
15. Outpatient rehabilitative physical therapy, occupational therapy, and speech therapy.

See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.

Care ceases to be *medically necessary rehabilitation* for any of the following:

9. The *member* has reached *maximum therapeutic benefit*.
10. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
11. There is no measurable progress toward documented goals.
12. 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* in-*network* care provided at the *member's* home and includes the following:

17. *Home health aide services*.
18. Services of a private duty registered nurse or licensed practical nurse rendered on an outpatient basis. Please refer to *your Summary of Benefits and Coverage (SBC)* for any limits associated with this *benefit*.
19. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
20. I.V. medication and pain medication.
21. Hemodialysis, and for the processing and administration of blood or blood components.
22. *Necessary medical supplies*, drugs and medicines, and laboratory services, to the extent they would have been covered if provided to the *member* on an impatient basis.
23. Rental of *medically necessary durable medical equipment*.
24. Sleep studies.

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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.

Limitations:
See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits for expenses related to *home health aide services*.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care under the Home Health Care Service Expense Benefit.

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a hospice care program. *Covered services* and supplies include:

17. Room and board in a *hospice* while the *member* is an *inpatient.*
18. Occupational therapy.
19. Speech-language therapy.
20. The rental of medical equipment while the *terminally ill covered person* is in a hospice care program to the extent that these items would have been covered under the *policy* if the *member* had been confined in a *hospital.*
21. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
22. Counseling the *member* regarding his or her *terminal illness.*

23. *Terminal illness counseling* of the *member's immediate family.*
24. *Bereavement counseling.*

Benefits for *hospice inpatient*, home and outpatient care are available.

Exclusions and *Limitations*:
Any *exclusion* or *limitation* contained in the *policy* regarding:

7. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
8. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
9. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Hospital Benefits

Covered service expenses are limited to charges made by a *hospital* for:

13. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
14. Daily room and board and nursing services while confined in an *intensive care unit*.
15. *Inpatient* use of an operating, treatment, or recovery room.
16. Outpatient use of an operating, treatment, or recovery room for *surgery.*
17. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
18. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your Summary of Benefits and Coverage (SBC)* for *limitations*.

Emergency Room Services

In an emergency situation (anything that could endanger *your* life (or *your* unborn child's life)), *you* should call 911 or head straight to the nearest emergency room. *We* cover emergency medical and behavioral health services both in and out of *our* service area. *We* cover these services 24 hours a day, 7 days a week.

Medical Expense Benefits

Medical *covered services* and supplies are limited to charges:

43. Made by a *physician* or *specialist* for professional services, including *surgery*.
44. For the professional services of a *medical practitioner*.
45. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
46. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included) which includes but are not limited to:
    1. Sleep disorder studies in home or facility which may require *prior authorization*;
    2. Bone density studies;
    3. Clinical laboratory tests;
    4. Gastrointestinal lab procedures;
    5. Pulmonary function tests.
47. For chemotherapy and radiation therapy or treatment.

48. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
49. For the cost and administration of an anesthetic.
50. For oxygen and its administration.
51. For *medically necessary chiropractic care* and acupuncture treatment on an outpatient basis only. Coverage limited to 20 visits/calendar year, unless it is habilitative and rehabilitative in nature. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
52. Family Planning for certain professional *provider* contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
53. *Medically necessary services* made by a *physician* in an *urgent care center*, including *facility* costs and supplies.
54. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
55. Allergy services including testing and sera.
56. Allergy serum extracts.
57. *Medically necessary telehealth* services subject to the same clinical and *utilization review* criteria, plan requirements, *limitations* and *cost sharing* as the same health care services when delivered to an insured in person.
58. For *medically necessary* genetic blood tests.
59. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
60. For *medically necessary* biofeedback services.
61. For *medically necessary* allergy treatment.
62. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
63. *Telehealth* services are covered for medical outpatient services and mental health and substance use disorder outpatient services.

Surgical Expense Benefits

Surgical *covered services* but not limited to charges:

17. For *surgery* in a *physician's* office, inpatient facility, or at an *outpatient surgical facility,* including services and supplies.
18. Made by an assistant surgeon.
19. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
20. For *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
21. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
22. Bariatric surgery for *members* with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at risk

for increased morbidity due to specific obesity related comorbid medical conditions.

23. Accidental Dental.
24. 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.

Mental Health and Substance Use Disorder Benefits

Our behavioral health and substance use vendor oversees the delivery and oversight of covered behavioral health and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our* behavioral health and substance use vendor's *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *You* can search for in-network Behavioral Health *providers* by using *our* Find a Provider tool at Ambetter.WesternSkyCommunityCare.com or by calling Member Services at 1-833-945-2029 (TDD/TTY 711). *Deductible amounts*, *copayment,* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most recent edition of the International Classification of Diseases (ICD-10).

When making coverage determinations, *our* behavioral health and substance use vendor utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and substance use vendor utilizes Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance abuse* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered Inpatient and Outpatient mental health and/or *substance use disorder* services are as follows:

Inpatient

15. *Inpatient* detoxification treatment;
16. Observation;
17. Crisis Stabilization;
18. *Inpatient rehabilitation*;
19. *Residential treatment facility* for mental health and *substance abuse*;

20. *Inpatient* Psychiatric Hospitalization; and
21. Electroconvulsive Therapy (ECT).

Outpatient

27. Individual and group mental health evaluation and treatment;
28. *Outpatient services* for the purpose of monitoring drug therapy;
29. Medication management services;
30. Outpatient detoxification programs;
31. Psychological and Neuropsychological testing and assessment;
32. Outpatient *rehabilitation* treatment;
33. *Applied Behavioral Analysis*;
34. Telemedicine;
35. Partial Hospitalization Program (PHP);
36. Intensive Outpatient Program (IOP);
37. Mental health day treatment;
38. Electroconvulsive Therapy (ECT);
39. *Transcranial Magnetic Stimulation (TMS)*

In addition, Integrated Care Management is available for all of *your* healthcare needs, including behavioral health and substance use. Please call 1-866-263-8134 (TDD/TTY 1-855-868-4945) to be referred to a care manager for an assessment.

Expenses for these services are covered, if *medically necessary* and may be subject to *prior authorization*. Please see the *Summary of Benefits and Coverage (SBC)* for more information regarding services that require *prior authorization* and specific benefit, day or visit limits, if any.

Other Dental Services

Anesthesia and *hospital* charges for dental care are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient *ambulatory surgical center* for the following:

1. *Members* exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
2. *Members* for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
3. *Eligible child* who is extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral dental morbidity;
4. *Members* with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
5. Other procedures for which hospitalization or general anesthesia in a *hospital* or *ambulatory surgical center* is *medically necessary*.

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. This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

Other *dental services* shall be limited to the following conditions when deemed *medically necessary*:

6. Accidental *injury* to sound natural teeth, jaw bones, or surrounding tissues;
7. Correction of a non-dental physiological condition which has resulted in a severe functional impairment; or
8. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth

Outpatient Medical Supplies Expense Benefits

Covered services and supplies for outpatient medical supplies are limited to charges:

17. 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.
18. For one pair of foot orthotics per year per *covered person*.
19. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
20. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
21. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
22. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
23. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery.
24. For the cost of one hearing aid per *eligible child* under the age of 18 (or under the age of 21 if still attending high school) who is a *member*. Hearing aid coverage offered shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician, licensed in New Mexico. Repairs and replacements are limited to once every three (3) years.

Pediatric Vision Expense Benefits

Coverage for vision services is provided for children under the age of 19, from a *network provider* through the end of the plan year in which they turn 19 years of age.

11. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
12. Frames
13. Prescription lenses
    a. Single;

b. Bifocal;
c. Trifocal;
d. Lenticular; or
e. Contact lenses (in lieu of glasses).

14. 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.
15. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Please refer to your *Summary of Benefits and Coverage (SBC)* for a detailed list of *cost sharing,* annual maximum and appropriate service limitations. To see which vision providers are part of the network, please visit Ambetter.WesternSkyCommunityCare.com or call Member Services.

Services not covered:

5. Visual therapy;
6. Two pair of glasses as a substitute for bifocals;
   Non-network care without *prior authorization.*

Prescription Drug Expense Benefits

We work with providers and pharmacists to ensure that *we* cover medications used to treat a variety of conditions and diseases. *We* will accept uniform *prior authorization* forms for prescription drugs as sufficient to request *prior authorization* for prescription drug benefits.

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

9. A *prescription drug.*
10. Prescribed, self-administered anticancer medication.
11. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
12. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or

b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

As used in this section, *Standard Reference Compendia* means (a) The American Hospital Formulary Service Drug Information, (b) The American Medical Association Drug Evaluation, or (c) The United States Pharmacopoeia-Drug Information.

Formulary or Prescription Drug List
The formulary or prescription drug list is a guide to available generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and covered through *your* prescription drug benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost effective treatment options, if a generic medication on the formulary is not suitable for *your* condition.

Please note, not all dosage forms or strengths of a drug may be covered. The formulary 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.WesternSkyCommunityCare.com (under "For Member", "Pharmacy Resources") or call Member Services at 1-833-945-2029 (TDD/TTY 711).

Over-the-Counter (OTC) Prescriptions
We cover a variety of over-the-counter (OTC) medications when ordered by a *physician. You* can find a list of covered over-the-counter medications in *our* formulary – they will be marked as "OTC". *Your* prescription must meet all legal requirements.

How to Fill a Prescription
Prescription can be filled at an in-network retail pharmacy or through *our* mail-order pharmacy.

If *you* decide to have *your* prescription filled at an in-network pharmacy, *you* can use the Provider Directory to find a pharmacy near *you*. *You* can access the Provider Directory at Ambetter.WesternSkyCommunityCare.com on the Find a Provider page. *You* can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with *your* prescription and *your member* ID card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high

blood pressure, asthma and diabetes. *You* can find a list of covered medications on Ambetter.WesternSkyCommunityCare.com. *You* can also request to have a copy mailed directly to *you*.

Mail Order Pharmacy

If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for *your* regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-239-7690. Alternatively, *you* can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on *our* Ambetter website. Once on *our* website, click on the section, "For Member," "Pharmacy Resources." The enrollment form will be located under "Forms."

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *medical practitioner.*

Non-Covered Services and *Exclusion*s:

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

37. For immunization agents, blood, or blood plasma, except when used for *preventive care* or required by ACA and listed on the formulary. This section does not preclude the coverage of aforementioned vaccines through the Medical Expense Benefits except for vaccines used in conjunction with travel to foreign counties.
38. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
39. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
40. For a refill dispensed more than 12 months from the date of a *physician's* order.
41. Due to a *member's* addiction to, or dependency, on foods.
42. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
43. 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 or when the over-the-counter drug is used for *preventive care*.
44. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
45. For more than a 30-*day* supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-*day* supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-*day* supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharing* mail orders less than 90 days are subject to the standard *cost sharing* amount.
46. 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.
47. Off-label use, except as required by law or as expressly approved by *us*.

48. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
49. Drugs or dosage amounts determined by Ambetter 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.
50. Foreign Prescription Medications, except those associated with an *emergency* medical condition while *you* are travelling outside the United States, or those *you* purchase while residing outside the United States, or those *you* purchase while residing outside the United States. These *exceptions* apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
51. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
52. For any claim submitted by non lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
53. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
54. For any injectable medication or biological product that is not expected to be self-administered by the *member* or *member's* place of residence unless listed on the formulary.

Prescription Drug Exception Process

Standard exception request

A *member*, a *member's* designee or a *member's* prescribing *physician* may request a standard review of a decision that a drug is not covered by the plan or a protocol *exception* for step therapy. The request can be made in writing or via telephone. Within 72 hours of the request being received, *we* will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with *our* coverage determination. Should the standard exception request or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the prescription, including refills, or of the drug that is the subject of the protocol *exception*.

Expedited exception request

A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, *we* will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with *our* coverage determination. Should the standard *exception* or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the exigency.

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make *our* determination on the external exception request and notify the *member*, the *member's* designee or the

member's prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.
If *we* grant an external exception review of a standard exception or step therapy protocol exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol *exception* for the duration of the exigency.

Preventive Care Expense Benefits

Preventive care expenses will not be limited based on an individual's sex assigned at birth, gender identity or recorded gender. Coverage and claims will not be denied or limited or subject to additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

13. 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. These recommendations include:
    a. Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;
    b. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese;
    c. Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a ≥10% 10-year cvd risk;
    d. Asymptomatic Bacteriuria in Adults: Screening: pregnant persons;
    e. BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation;
    f. Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer;
    g. Breast Cancer: Screening: women aged 50 to 74 years;
    h. Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children;
    i. Cervical Cancer: Screening: women aged 21 to 65 years;
    j. Colorectal Cancer: Screening: adults aged 50 to 75 years;
    k. Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
    l. Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
    m. Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;

n. Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;
o. Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy;
p. Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation;
q. Chlamydia and Gonorrhea: Screening: sexually active women;
r. Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling: adults who are overweight or obese and have additional cvd risk factors;
s. Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;
t. Hepatitis B Virus Infection: Screening, 2014: persons at high risk for infection;
u. Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
v. Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
w. Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
x. High Blood Pressure in Adults: Screening: adults aged 18 years or older;
y. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
z. Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
aa. Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication : pregnant women who are at high risk for preeclampsia;
bb. Lung Cancer: Screening: adults aged 55-80, with a history of smoking;
cc. Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;
dd. Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
ee. Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
ff. Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
gg. Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
hh. Preeclampsia: Screening: pregnant woman;
ii. Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of hiv acquisition;
jj. Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
kk. Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women;
ll. Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
mm. Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults;
nn. Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children;

oo. Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10% or greater;
pp. Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
qq. Syphilis Infection in Pregnant Women: Screening: pregnant women;
rr. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
ss. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women;
tt. Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
uu. Unhealthy Drug Use: Screening: adults age 18 years or older;
vv. Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years;
ww. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults.

Note: The full list of recommendations and descriptions can be found at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations. Please be advised that these recommendations are subject to change. *Members* are encouraged to visit the website provided for the most up-to-date listing of recommendations.

14. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
15. Evidence-informed *preventive care* and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
16. Additional *preventive care* and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
17. Childhood immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics, including coverage for all *medically necessary* booster doses of all immunizing agents used in childhood immunizations.
18. Covers without *cost sharing*:
    a. Screening for *tobacco or nicotine use*; and
    b. For those who *use tobacco or nicotine* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-*day* treatment regimen when prescribed by a health care *provider* without *prior authorization*.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *policy* when the services are provided by a *participating provider.* If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you're* getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III, or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:

- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Phase I and II clinical trials must meet the following requirements:

- Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
- The insured is enrolled in the clinical trial. This section shall not apply to insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Phase III and IV clinical trials must be approved or funded by one of the following entities:

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- An NIH Cooperative Group or Center;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans' Affairs, Defense, or Energy;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating *facility* and personnel must have the expertise and training to provide the

treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.
Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

Benefits for *covered expenses* for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *participating providers*. Reasonable medical management techniques may result in the application of *deductible amounts*, *coinsurance* provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from *deductible amounts*, *coinsurance* provisions, and *copayment amounts*, when received from a *participating provider*.

As new recommendations and guidelines are issued, those services will be considered *covered service expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Cytological Screening
Covered service expenses include one annual cytologic screening test for a *member* beginning at age 18.

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and at risk, one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Maternity Care
Coverage for outpatient and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be

provided for maternity services or care of the newborn child when such services have been *authorized* by *your* participating health care *provider*.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered service expenses* incurred for a shorter stay if the attending *provider* (e.g., *your physician*, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a *physician* or other health care *provider* obtain *authorization* for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for maternity care.

(1) Give birth in a *hospital* or other healthcare *facility*
(2) Remain under *inpatient* care in a *hospital* or other healthcare *facility* for any fixed term following the birth of a child

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please see General Non-Covered Services and Exclusions.

Duty to Cooperate

Members who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 *days* of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* in accordance with the notice requirements set forth in General Provisions herein. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborn Charges

Medically necessary services, including hospital services, are provided for a covered newborn child immediately after birth. Covered services include well baby visits and care. Each type of covered service incurred by the newborn child will be subject to his/her own cost sharing (copayment, coinsurance percentage, deductible and maximum out-of-pocket amount), as listed in the *Summary of Benefits and Coverage (SBC)*. Please refer to the Dependent Member Coverage section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

Medical Foods

We cover medical foods and formulas for outpatient total parenteral nutritional therapy; nutritional counseling when prescribed by an in-network *medical practitioner*/*provider* and administered by enteral tube feedings; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

Exclusions: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Newborns' and Mothers' Health Protection Act Statement of Rights
If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least once annually for a *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Covered Preventive Services for Women and Pregnant Women include:
1. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
2. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
3. Domestic and interpersonal violence screening and counseling for all *members*;
4. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
5. Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists, or its successor organization;
6. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
7. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
8. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
9. Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast feeding counseling
10. *Pregnancy* related diagnostic tests, including an alpha-fetoprotein IV screening test generally between 16 to 20 weeks of *pregnancy*, to screen for certain abnormalities in the fetus;
11. Sterilization services for women only;
12. Well-woman visits to obtain recommended preventive services.

Respite Care Expense Benefits
Respite care is covered on an *inpatient* or outpatient basis to allow temporary relief to family members from the duties of caring for a *covered person* under Hospice Care. Respite days that are applied toward the

deductible amount are considered benefits provided and shall apply against any maximum benefit limit for these services. See *your Summary of Benefits and Coverage (SBC)* for coverage limits.

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a covered benefit (e.g., X-ray, MRI, CT scan, PET/SPECT, mammogram, ultrasound). Prior authorization may be required, see the *Summary of Benefits and Coverage (SBC)* for details. Note: Depending on the service performed, two bills may be incurred - both subject to any applicable cost sharing - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a physician or other qualified practitioner).

Second Medical Opinion

Members are entitled to a second medical opinion under the following conditions:

7. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
8. Whenever a serious *injury* or *illness* exists; or
9. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

If requested, the *second opinion* consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *participating provider* listed in the Healthcare Provider Directory. If a *member* chooses a *participating provider*, he or she will only be responsible for the applicable *copayment* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *copayment*.

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to enrollees to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this contract. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All enrollees are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this contract by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services at 1-833-945-2029 (TDD/TTY 711).

Telehealth Service Benefits

Telehealth services are covered for medical outpatient services and mental health and substance use disorder outpatient services. *Telehealth* services are covered on the same basis and to the same extent that

we would otherwise provide coverage for the same service when provided through an in-person consultation or contact and the type of setting where these services are provided is not limited. An in-person consultation or contact is not required for coverage of *telehealth services* unless the consulting telemedicine provider deems it necessary.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

Transplants are a covered benefit when a member is accepted as a transplant candidate and pre-*authorized* in accordance with this *contract*. *Prior authorization* must be obtained through the *"Center of Excellence",* before an evaluation for a transplant. *We* may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Cost share benefit coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:

9. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
10. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollees benefits.
11. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this contract will be provided for you. However, no benefits will be provided for the recipient.
12. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

If *we* determine that a *member* and donor are an appropriate candidate for a *medically necessary transplant,* live donation, covered service expense benefits will be provided for:

19. Pre-transplant evaluation.
20. Pre-transplant harvesting of the organ from the donor.
21. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
22. 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.
23. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
24. 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 participating facility.
25. Post-transplant follow-up visits and treatments.
26. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.

27. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations.

These medical expenses are covered to the extent that the benefits remain and are available under the *member's contract,* 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 contract*.

Ancillary "Center Of Excellence" Service Benefits:

A *member* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence:*

5. *We* will pay for the following services when the *member* us required to travel more than 75 miles from the *residence* to the *Center of Excellence*
6. *We* will pay a maximum of $10,000 per *transplant* service for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the member's home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the member transplant reimbursement guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
    f. Please refer to the member resources page for member reimbursement transplant travel forms and information at www. Ambetter.com.

Covered Transplant Expense Benefits:

Benefits will be provided or paid under these Transplant Expense Benefits:

15. Heart transplants.
16. Lung transplants.
17. Heart/lung transplants.
18. Kidney transplants.
19. Liver transplants.
20. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.

d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
e. *BMT* for Chronic Myelogenous Leukemia.
f. *ABMT* for Testicular Cancer.
g. *BMT* for Severe Combined Immunodeficiency.
h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
i. *BMT* for Myelodysplastic Syndrome.
j. *BMT* for Wiskott-Aldrich Syndrome.
k. *BMT* for Thalassemia Major.
l. *BMT* or *ABMT* for Multiple Myeloma.
m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
n. *BMT* for Fanconi's anemia.
o. *BMT* for malignant histiocytic disorders.
p. *BMT* for juvenile.

21. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

21. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
22. For animal to human transplants.
23. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
24. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence*.
25. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
26. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
27. 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 ("USFDA") regulation, regardless of whether the trial is subject to *FDA* oversight.
28. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence*.
29. For any transplant services and/or travel related expenses for enrollee and donor, when preformed outside of the United States.
30. The following ancillary items listed below, will not be subject to member reimbursement under this policy:
    a. Alcohol/tobacco

b. Car Rental (unless pre-approved by Case Management)
c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
e. Storage rental units, temporary housing incurring rent/mortgage payments.
f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
g. Speeding tickets
h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
j. Expenses for persons other than the patient and his/her covered companion
k. Expenses for lodging when member is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
r. All other items not described in the policy as eligible expenses
s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification
At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving *immunosuppressant drugs* or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, *We* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or guardian if the patient is a child, or the *spouse* of a patient who is *authorized* to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.
As an alternative to providing written notice, *we* may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.
At the time a patient requests a refill of the immunosuppressant drug, *we* may provide the patient with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

Limitations on Transplant Service Expense Benefits:
In addition to the *exclusions* and *limitations* specified elsewhere in this section:

7. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member*.

8. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the *Summary of Benefits and Coverage (SBC)* for benefit levels or additional limits.
9. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits

Benefits may be available to *members* for participating in certain programs that *we* may make available in connection with this *policy*. Such programs may include wellness programs, disease or *case management* programs, and other programs as found under the Health Management Programs Offered provision. These programs may include a reward or an incentive, which you may earn by completing different activities.

If *you* have a medical condition that may prohibit *you* from participating in these programs, *we* may require *you* to provide verification, such as an affirming statement from *your* physician, that *your* medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program, in order for *you* to receive the reward or incentive.

You may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.WesternSkyCommunityCare.com or by contacting Member Services by telephone at 1-833-945-2029 (TTY/TDD 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by us through updates available on *our* website or by contacting *us*.

Care Management Programs

We understand special health needs and are prepared to help *you* manage any that *you* may have. *Our* Care Management services can help with complex medical or behavioral health needs. If *you* qualify for Care Management, *we* will partner *you* with a care manager. Care managers are registered nurses or social workers that are specially trained to help *you*:

- Better understand and manage *your* health conditions
- Coordinate services
- Locate community resources

Your care manager will work with *you* and *your* doctor to help *you* get the care *you* need. If *you* have a severe medical condition, *your* care manager will with *you*, *your primary care provider (PCP)* and other *providers* to develop a care plan that meet *your* needs and *your* caregiver's needs. If *you* think *you* could benefit from *our* Care Management program, please call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

9. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
10. Any services performed by a *member* of a *member's immediate family.*
11. Any services not identified and included as *covered service expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*
12. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

5. Administered or ordered by a *physician;* and
6. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

69. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
70. For any portion of the charges that are in excess of the *eligible service expense.*
71. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric surgery and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
72. For the reversal of sterilization and the reversal of vasectomies.
73. For non-therapeutic abortion.
74. For expenses for television, telephone, or expenses for other persons.
75. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
76. For telephone consultations or for failure to keep a scheduled appointment.
77. For stand-by availability of a *medical practitioner* when no treatment is rendered.
78. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
79. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
80. For diagnosis or treatment of learning disabilities.
81. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
82. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
83. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

84. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
85. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
86. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
87. 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*.
88. For hearing aids, except as expressly provided in this *policy*.
89. 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.
90. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive *days*. If travel extends beyond 90 consecutive *days*, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 *days*.
91. 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.
92. For or related to treatment of hyperhidrosis (excessive sweating).
93. For fetal reduction surgery.
94. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
95. 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).
96. 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.

97. 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.
98. 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 section; routine foot care except when related to diabetes, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
99. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
100. For court ordered testing or care unless *medically necessary*.
101. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party.*

    surrogacy arrangement. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This *exclusion* applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.
102. For any medicinal and recreational use of cannabis or marijuana.

Note: This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent or the New Mexico Health Insurance Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

Limitations on Benefits for Services Provided by Medicare Opt-Out Practitioners
Benefits for *covered service expenses* incurred by a *Medicare*-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if *Medicare* had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

Termination

Termination of Policy
All coverage will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

15. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
16. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request;
17. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
18. The date of *your* death, if this *policy* is an Individual Plan;
19. The date that a *member* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes. If an HRA is offered, employer payments would be acceptable and exempt from the limitation;
20. 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
21. The date a *member's* eligibility for coverage under this *policy* ceases as determined by *us*.

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 written notice, delivered, or mailed to the Exchange, or if an off-exchange *member* by written notice, delivered, or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 *days*. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

Reinstatement
We will reinstate a *policy* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew 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 and refuse to renew 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.

Benefits After Coverage Terminates

Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

7. A request by *you*;
8. Fraud or material misrepresentation on *your* part; or
9. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*. The *period of extended loss* must begin before coverage of the *member* ceases under this *policy*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

5. The date the *continuous loss* ends; or
6. 12 months after the date renewal is declined.

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 *injuries* or *illness* are referred to as "third party injuries." "Responsible party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of third party injuries.

If this plan provides benefits under this *policy* to a *member* for expenses incurred due to third party injuries, then Western Sky Community Care, Inc. retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the third party injuries. Western Sky Community Care, Inc.'s rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and
- Any other payments from a source intended to compensate a *member* for third party injuries.

By accepting benefits under this plan, the *member* specifically acknowledges Western Sky Community Care, Inc.'s right of recovery. When this plan provides health care benefits for expenses incurred due to third party injuries, Western Sky Community Care, Inc. shall be included in the *member's* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. Western Sky Community Care, Inc. may proceed against any party with or without the *member's* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges Western Sky Community Care, Inc.'s right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to third party injuries and the *member* or the *member's* representative has recovered any amounts from any source. Western Sky Community Care, Inc.'s right of reimbursement is cumulative with and not exclusive of Western Sky Community Care, Inc.'s right of recovery and Western Sky Community Care, Inc. may choose to exercise either or both rights of recovery.

As a condition for *our* payment, the *member* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

23. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
24. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
25. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
26. To give Western Sky Community Care, Inc. a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
27. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Western Sky Community Care, Inc. as reimbursement for

the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

28. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.
29. 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.
30. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement rights.
31. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
32. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
33. That *we* may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse *us*.

We have the right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit. In the event *you* or *your* representative fail to cooperate with Western Sky Community Care, Inc., *you* shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Western Sky Community Care, Inc. in obtaining repayment.

If a dispute arises as to the amount a *member* must reimburse *us*, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Coordination of Benefits

Ambetter coordinates benefits with other payers when a *member* is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit policies. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

13. 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.
14. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
15. Plan includes *hospital*, medical, and surgical benefits coverage of *Medicare* or a governmental plan offered, required, or provided by law, except Medicaid.
16. 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.
17. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through *health maintenance organizations (HMO's)* or coverage under other prepayment, group practice and individual practice plans.
18. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any *other plan* into consideration. A plan is primary if either:

5. The plan has no order of benefits rules or its rules differ from those required by regulation; or
6. 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:

15. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that *other plan*.
16. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two *exceptions*:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the policy holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

17. If the person receiving benefits is the *member* and is only covered as an *eligible dependent* under the *other plan*, this *policy* will be primary.
18. Subject to State Statues: Social Security Act of 1965, as amended makes *Medicare* secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
19. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    a. The plan of the parent who has custody will be primary.
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

20. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
21. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each *covered service*. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain facts about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and *other plans*. *We* may get the facts *we* need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and *other plans* covering the person claiming benefits. *We* need not tell or get the consent of, any person to do this.

Claims

Notice of Claim
We must receive notice of claim within 30 *days* of the date the *loss* began or as soon as reasonably possible.

Proof of Loss
We must receive written *proof of loss* within 90 *days* of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent member* had no legal capacity to submit such proof during that year.

How to Submit a Claim
Providers will typically submit claims on *your* behalf, but sometimes *you* may need to submit claims yourself for *covered services*. This usually happens if:

- *Your provider* is not contracted with *us*
- *You* have an out-of-area emergency.

If *you* have paid for services *we* agreed to cover, *you* can request reimbursement for the amount *you* paid. *We* can adjust *your deductible*, *copayment* or *cost sharing* to reimburse *you*.

To request reimbursement for a *covered service*, *you* need a copy of the detailed claim from *your provider*. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at Ambetter.WesternSkyCommunityCare.com under "Member Resources." Send all the documentation to *us* at the following address:

Ambetter from Western Sky Community Care
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

9. 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.
10. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
11. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
12. Furnish any other information, aid or assistance that *we* may require, including without *limitation*, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by

us unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 *days* for clean claims filed electronically or on paper. "Clean claims" means a claim submitted by *you* or a *provider* that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. *You* will receive a copy of that request for additional information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 20 *days* of *our* initial receipt of the claim and will complete *our* processing of the claim within 30 *days* after *our* receipt of all requested information.

Payment of Claims
Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent member's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent member's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to $1,000 to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable *medical records* in English to show proper *proof of loss* and evidence of payment to the *provider*.

Assignment
We will reimburse a *hospital* or health care *provider* if:

5. *Your* health insurance benefits are assigned by *you* in writing; and
6. *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:

5. A *member* is eligible for coverage under his or her state's Medicaid program; and
6. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

Custodial Parent
This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *member*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

7. Provide the custodial parent with information regarding the terms, conditions, benefits, *exclusions*, and *limitations* of the *policy*;
8. Accept claim forms and requests for claim payment from the custodial parent; and
9. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

Physical Examination
We shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

Legal Actions
No suit may be brought by *you* on a claim sooner than 60 *days* after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of an Ambetter decision. *You* will be provided with detailed information and complaint forms by Ambetter at each step. In addition, *you* can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau** page found under the **Departments** tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. *You* may also request a copy of the regulations in one of two ways:

5. Send a request in writing to Ambetter at:
   Ambetter from Western Sky Community Care, Inc.
   5300 Homestead Road NE
   Albuquerque, NM 87110
   Member Services: 1-833-945-2029 (TDD/TTY: 711)
   Fax: 1-833-886-7956
   Web address: Ambetter.WesternSkyCommunityCare.com
   Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

6. From the OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?
You may request a review of two different types of decisions:

Adverse Determination: *You* may request a review if Ambetter has denied pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure *you* have already received, or is denying or reducing further payment for an ongoing procedure that *you* are already receiving and that has been previously covered. (*We* must notify *you* before terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be *experimental*, *investigational*, or not *medically necessary* or appropriate. It may also include a denial by Ambetter of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative Decision: *You* may also request a review if *you* object to how Ambetter handles other matters, such as *our* administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if *your* coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a health care service work?
When Ambetter receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse *your* healthcare provider (*provider*) for a service that *you* have already had, it follows a two-step process.

Coverage: First, *we* determine whether the requested service is covered under the terms of your health benefits plan (*policy*). For example, if *your policy* excludes payment for adult hearing aids, then *we* will not agree to pay for *you* to have them even if *you* have a clear need for them.
Medical necessity: Next, if Ambetter finds that the requested service is covered by the *policy*, Ambetter determines, in consultation with a physician, whether a requested service is *medically necessary*. The consulting physician determines medical necessity either after consultation with *specialists* who are experts in the area or after application of uniform standards used by Ambetter. For example, if *you* have a crippling hand injury that could be corrected by plastic surgery and *you* are also requesting that Ambetter pay for cosmetic plastic surgery to give *you* a more attractive nose, Ambetter might certify the first request to repair *your* hand and deny the second, because it is not *medically necessary*.

Depending on terms of your policy, Ambetter might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, Ambetter may deny certification. Ambetter might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If Ambetter determines that it will not certify your request for services, *you* may still go forward with the treatment or procedure. **However,** *you* will be responsible for paying the *provider* yourself for the services.

How long does initial certification take?
Standard decision: Ambetter must make an initial decision within 5 working days. However, Ambetter may extend the review period for a maximum of 10 calendar days if it:

7. Can demonstrate reasonable cause beyond *our* control for the delay;
8. Can demonstrate that the delay will not result in increased medical risk to *you*; and
9. Provide a written progress report and explanation for the delay to *you* and *your provider* within the original 5 working day review period.

What if I need services in a hurry?
Urgent care situation: An **urgent care situation** is a situation in which a decision from Ambetter is needed quickly because:

11. Delay would jeopardize *your* life or health;
12. Delay would jeopardize *your* ability to regain maximum function;
13. The *physician* with knowledge of *your* medical condition **reasonably** requests an expedited decision;
14. The *physician* with knowledge of *your* medical condition, believes that delay would subject *you* to severe pain that cannot be adequately managed without the requested care or treatment; or
15. The medical demands of *your* case require an expedited decision.

If *you* are facing an urgent care situation **or** Ambetter has notified *you* that payment for an ongoing course of treatment that *you* are already receiving is being reduced or discontinued, *you* or *your provider* may request an expedited review and Ambetter must either certify or deny the initial request quickly. Ambetter

must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

If *you* are dissatisfied with Ambetter's initial expedited decision in an urgent care situation, *you* may then request an **expedited review** of Ambetter's decision by both Ambetter and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, Ambetter must review its prior decision and respond to *your* request within 72 hours. If *you* request that an IRO perform an expedited review simultaneously with Ambetter's review and *your* request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records. If *you* are still dissatisfied after the IRO completes its review, *you* may request that the Superintendent review *your* request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If *you* are facing an *emergency*, you should seek medical care immediately and then notify Ambetter as soon as possible. Ambetter will guide *you* through the claims process once the *emergency* has passed.

When will I be notified that my initial request has been either certified or denied?
If the initial request is approved, Ambetter must notify *you* and *your provider* within 1 working day after the decision, unless an urgent matter requires a quicker notice. If Ambetter denies certification, Ambetter must notify *you* and the *provider* within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?
If *your* initial request for services is denied or *you* are dissatisfied with the way Ambetter handles an administrative matter, *you* will receive a detailed written description of the grievance procedures from Ambetter as well as forms and detailed instructions for requesting a review. *You* may submit the request for review either orally or in writing depending on the terms of *your policy*. Ambetter provides representatives who have been trained to assist *you* with the process of requesting a review. This person can help *you* to complete the necessary forms and with gathering information that *you* need to submit *your* request. For assistance, contact Member Services as follows:

Telephone: 1-833-945-2029
Address: Ambetter from Western Sky Community Care Grievances and Appeals Department
12515-8 Research Blvd., Ste. 400
Austin, TX 78759
FAX #: 1-833-751-0895
Email: Ambetter_Centralized_Grievances_Appeals@CENTENE.COM

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:
Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674

Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?
A review may be requested by *you* as the patient, *your provider*, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review
If *you* are dissatisfied with the initial decision by Ambetter, *you* have the right to request that Ambetter's decision be reviewed by its medical director. The medical director may make a decision based on the terms of *your policy*, may choose to contact a *specialist* or the *provider* who has requested the service on your behalf, or may rely on Ambetter's standards or generally recognized standards.

Time limit for requesting a review
You must notify Ambetter that *you* wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What you need to provide
If *you* request that Ambetter review its decision, *we* will provide *you* with a list of the documents *you* need to provide and will provide to *you* all of *your* records and other information the medical director will consider when reviewing *your* case. *You* may also provide additional information that *you* would like to have the medical director consider, such as a statement or recommendation from *your* doctor, a written statement from *you*, or published clinical studies that support *your* request.

How Long a First Level Review Takes

Expedited review. If a review request involves an urgent care situation, Ambetter must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. Ambetter must complete both the medical director's review and (if *you* then request it) Ambetter's internal panel review within 30 days after receipt of *your* pre-service request for review or within 60 days if *you* have already received the service. The medical director's review generally takes only a few days.

What to do if the Medical Director denies your request
If *you* remain dissatisfied after the medical director's review, *you* may either request a review by a panel that is selected by Ambetter or *you* may skip this step and ask that *your* request be reviewed by an IRO that is appointed by the Superintendent.

- If *you* ask to have your request reviewed by Ambetter's panel, then *you* have the right to appear before the panel in person or by telephone or have someone, (including *your* attorney), appear with *you* or on your behalf. *You* may submit information that *you* want the panel to consider, and ask questions of the panel members. *Your* health *provider* may also address the panel or send a written statement.
- If *you* decide to skip the panel review, *you* will have the opportunity to submit *your* information for review by the IRO, but *you* will not be able to appear in person or by telephone. OSI can assist *you* in getting your information to the IRO.

IMPORTANT: If *you* are covered under the NM State Healthcare Purchasing Act, *you* may NOT request an IRO review if *you* skip the panel review.

How long you have to make a decision
If you wish to have your request reviewed by Ambetter's panel, you must inform us within 5 days after you receive the medical director's decision. If you wish to skip Ambetter's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within 4 months after you receive the medical director's decision.

What happens during an Ambetter panel review?
If *you* request that Ambetter provide a panel to review its decision, Ambetter will schedule a hearing with a group of medical and other professionals to review the request. If *your* request was denied because Ambetter felt the requested services were not *medically necessary*, were *experimental* or were *investigational*, then the panel will include at least one *specialist* with specific training or experience with the requested services.

Ambetter will contact *you* with information about the panel's hearing date so that *you* may arrange to attend in person or by telephone, or arrange to have someone attend with *you* or on *your* behalf. *You* may review all of the information that Ambetter will provide to the panel and submit additional information that *you* want the panel to consider. If *you* attend the hearing in person or by telephone, *you* may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.

Ambetter's internal panel must complete its review within 30 days following *your* original request for an internal review of a request for pre-certification or within 60 days following *your* original request if *you* have already received the services. *You* will be notified within 1 day after the panel decision. If *you* fail to provide records or other information that Ambetter needs to complete the review, *you* will be given an opportunity to provide the missing items, but the review process may take much longer and *you* will be forced to wait for a decision.

Hint: If *you* need extra time to prepare for the panel's review, then *you* may request that the panel be delayed for a maximum of 30 days.

If you choose to have your request reviewed by the Ambetter panel, can you still request the IRO review?

Yes. If *your* request has been reviewed by Ambetter's panel and *you* are still dissatisfied with the decision, *you* will have **4 months** to request a review by an IRO.

What's an IRO and what does it do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with Ambetter or with *you*. The reviewer will consider all of the information that is provided by Ambetter and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, Ambetter, and to OSI. Ambetter must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then Ambetter must provide them.
The IRO's fees are billed directly to Ambetter – there is no charge to you for this service.

How long does an IRO review take?
The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance
If *you* remain dissatisfied after the IRO's review, *you* may still be able to have the matter reviewed by the Superintendent. *You* may submit *your* request directly to OSI, and if *your* case meets certain requirements, a hearing will be scheduled. *You* will then have the right to submit additional information to support *your* request and *you* may choose to attend the hearing and speak. *You* may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.
The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to *you* for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to Ambetter. However, if *you* arrange to be represented by an attorney or *your* witnesses require a fee, *you* will need to pay those fees.

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?
If *you* are dissatisfied with an initial administrative decision made by Ambetter, *you* have a right to request an internal review within **180 days** after the date *you* are notified of the decision. Ambetter will notify *you*

within 3 days after receiving *your* request for a review and will review the matter promptly. *You* may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?
Ambetter will mail a decision to *you* within 30 days after receiving *your* request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?
Yes. *You* have **20 days** to request that Ambetter form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?
When Ambetter receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after Ambetter receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by Ambetter, you may request that the committee hearing be postponed for up to 30 days.
The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?
If *you* are dissatisfied with the reconsideration committee's decision, *you* may ask the Superintendent to review the matter within **20 days** after *you* receive the written decision from Ambetter. *You* may submit the request to OSI using forms that are provided by Ambetter. Forms are also available on the OSI website located at www.osi.state.nm.us. *You* may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674.

How does the external review work?
Upon receipt of *your* request, the Superintendent will request that both *you* and Ambetter submit information for consideration. Ambetter has 5 days to provide its information to the Superintendent, with a copy to *you*. *You* may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both *you* and Ambetter and issue a final decision within 45 days. If *you* need extra time to gather information, *you* may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality
Any person who comes into contact with *your* personal health care records during the grievance process must protect *your* records in compliance with state and federal patient confidentiality laws and regulations. In fact, the *provider* and Ambetter cannot release *your* records, even to OSI, until *you* have signed a release.

Special needs and cultural and linguistic diversity
Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements
Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. *You* may review the results of the annual reports on the OSI website.
The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

General Provisions

Entire Policy

This *policy,* with the application, is the entire *policy* between *you* and *us.* No agent may:

9. Change this *policy*;
10. Waive any of the provisions of this *policy*;
11. Extend the time for payment of premiums; or
12. Waive any of *our* rights or requirements.

Non-Waiver

If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, *limitations* or *exclusions* of the *policy* that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions

No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

7. The misrepresented fact is contained in a written application, including amendments, signed by a *member;*
8. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
9. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information

During the first two years a *member* is covered under the *policy*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *policy*.

Conformity with State Laws

Any part of this *policy* in conflict with the laws of New Mexico on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of New Mexico state law.

Personal Health Information

Your health information is personal. *We* are committed to do everything *we* can to protect it. *Your* privacy is also important to *us*. *We* have policies and procedures in place to protect *your* health records.

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPPA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like

the complete notice, please visit https://Ambetter.WesternSkyCommunityCare.com/privacy-practices.html or call Member Services at 1-866-263-8134 (TDD/TTY 1-855-868-4945).

We protect all of *your* PHI. *We* follow HIPPA to keep *your* healthcare information private.

Language
If *you* don't speak or understand the language in *your* area, *you* have the right to an interpreter. For language assistance, please visit: https://Ambetter.WesternSkyCommunityCare.com/language-assistance.html.

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care , tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [Phone Number]

Navajo: Din4 k'ehj7 y1n7[ti'go ata' hane' n1 h0l= d00 naaltsoos t'11 Din4 k'ehj7 bee bik'e'ashch98go nich'8' 1dooln7i[go bee haz'3 a[d0' 1ko d77 t'11 1t'4 t'11 j77k'e k0t'4ego nich'8' 22'1t'4. Koj8' h0lne' [Phone Number]

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Western Sky Community Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi [Phone Number].

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer [PhoneNumber] an.

Chinese: 如果您，或是您正在協助的對象，有關於 Ambetter from Western Sky Community Care方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 [Phone Number]。

Arabic: إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Western Sky Community Care ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ [Phone Number].

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Western Sky Community Care에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [Phone Number] 로 전화하십시오.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa [Phone Number].

Japanese: Ambetter from Western Sky Community Careについて何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、[Phone Number].までお電話ください。

French: Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le [Phone Number]

Italian: Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Western Sky Community Care, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'[Phone Number].

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Western Sky Community Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону [Phone Number].

Hindi: आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Western Sky Community Care के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए [Phone Number] पर कॉल करें।

Persian: اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Western Sky Community Care دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره [Phone Number] تماس بگیرید.

Thai: หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข [Phone Number].

Statement of Non-Discrimination

Ambetter from Western Sky Community Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Western Sky Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Western Sky Community Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Western Sky Community Care at 1-833-945-2029 (TTY/TDD 711)

If you believe that Ambetter from Western Sky Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Western Sky Community Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
www.osi.state.nm.us

To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit https://www.nmag.gov/consumer-complaint-instructions.aspx.

State of New Mexico Office of the Attorney General
408 Galisteo Street
Villagra Building
Sante Fe, NM 87501
Toll Free (844) 255-9210
Phone: (505) 490-4060
Fax: (505) 490-4883

AMB20-NM-C-00189

Declaración de no discriminación

Ambetter from Western Sky Community Care cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Ambetter from Western Sky Community Care no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter from Western Sky Community Care:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
  - Intérpretes calificados de lenguaje por señas
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter from Western Sky Community Care a at 1-833-945-2029 (TTY/TDD 711)

Si considera que Ambetter from Western Sky Community Care no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo o fax. Si necesita ayuda para presentar una queja, Ambetter from Western Sky Community Care está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html*.

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
www.osi.state.nm.us

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