



FROM



2022

Quick Reference Guide

The Resources You Need. Right Here.

For more information, visit [Ambetter.SilverSummitHealthplan.com](https://www.ambetter.silversummithealthplan.com)

If this information is not in your primary language, please call 1-866-263-8134 (TTY/TDD 1-855-868-4945)



FROM



Welcome to Ambetter from SilverSummit Healthplan!

Thank you for choosing us as your health insurance plan. We're excited to help you take charge of your health and to help you lead a healthier, more fulfilling life.

As our member, you have access to lots of helpful services and resources. This Quick Reference Guide (QRG) will help you understand all of them. Inside, you'll find important information about:

- How your plan works
- Payment information
- Where to go for care
- Information on your Member ID
- Optional adult dental and vision benefits
- Telehealth
- And much more!

YOUR HEALTH IS OUR PRIORITY.

If you have questions, we're always ready to help. And don't forget to check out our online video library at Ambetter.SilverSummitHealthplan.com. It's full of useful information.

Member Services:

1-866-263-8134 (TTY/TDD 1-855-868-4945)

Ambetter.SilverSummitHealthplan.com



How To Contact Us

How To Contact Us

Ambetter from SilverSummit Healthplan

2500 North Buffalo Drive

Las Vegas, NV 89128

If you want to talk, we're available

Monday through Friday, 8 a.m. – 8 p.m. PST.

| | |
|----------------------------|--|
| Member Services | 1-866-263-8134 |
| Fax | 1-855-252-0568 |
| TTY/TDD | 1-855-868-4945 |
| Make a Payment | 1-866-263-8134 |
| Behavioral Health Services | 1-866-263-8134 |
| 24/7 Nurse Advice Line | 1-866-263-8134 |
| Complaints and Grievances | 1-866-263-8134 |
| Emergency | 911 |
| Website | Ambetter.SilverSummitHealthplan.com |

When you call, have these items ready:

- Your ID
- Your claim number or invoice for billing questions

Interpreter Services

Please call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945) for free interpreter services as needed. Interpreter services include languages other than English. This service allows you and your provider to talk about your medical or behavioral health concerns in a way that is most comfortable for you. Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

How Your Plan Works

Learn about how to get the most out of your plan. Set up your online member account to get started.



Want more information about our service area and in-network providers? Visit Ambetter.SilverSummitHealthplan.com

So You Have Health Insurance — Now What?

Having health insurance is exciting. To get the most out of your plan, complete this simple checklist. If you need assistance, call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945). We're available Monday through Friday, 8 a.m. to 8 p.m. PST.

- 1** Set up your secure online member account. Do this by visiting the "Member Login" page on Ambetter.SilverSummitHealthplan.com. Your member account stores all of your plan's benefits and coverage information in one place. It gives you access to your *Schedule of Benefits*, claims information, this QRG and more.
- 2** Our *myhealthpays*® program helps you focus on your total health. When you complete healthy activities, such as eating right, moving more, saving smart and living well, you can earn reward points! All you have to do is log in to your online member account to get started.
- 3** Enroll in automatic bill pay. Call us or log in to your online member account to sign up. Automatic bill pay automatically withdraws your monthly premium payment from your bank account. It's simple, helpful, convenient and secure.
- 4** Pick your primary care provider (PCP). Just log in to your member account and view a list of Ambetter providers in your area by using the *Provider Directory* available on our website. Remember, your PCP, also known as a personal doctor, is the main doctor you will see for most of your medical care. This includes your checkups, sick visits and other basic health needs.
- 5** Schedule your annual wellness exam with your PCP. After your first checkup, you'll earn 500 points in *myhealthpays*® rewards! And anytime you need care, call your PCP and make an appointment!



Answers To Your Payment Questions



If you have questions about paying your premium, give member services a call at 1-866-263-8134 (TTY/TDD 1-855-868-4945).



Sign up for Paperless Billing to receive your monthly invoices online.

How Can I Pay My Monthly Premium?

1. Pay online (Our recommendation!)

- a. **Quick Payment:** <https://centene.softtheon.com/Equity/#/search> or visit Ambetter.SilverSummitHealthplan.com and select “pay now”.
- b. **Secure Member Account:** Create your online member account on Ambetter.SilverSummitHealthplan.com and enroll in automatic bill payment. You can set up automatic bill pay using your credit card, prepaid debit card, bank debit card or bank account. You can also make a one-time payment via your online member account.

2. Pay by phone

- a. Pay by Automated Phone. Call us at 1-844-PAY-BETTER (729-2388) and use our Interactive Voice Response (IVR) system. It’s quick and available 24/7!

Or

- b. Call billing services at 1-866-263-8134 (TTY/TDD 1-855-868-4945) between 8 a.m. and 8 p.m. PST. You will have the option to pay using the Interactive Voice Response (IVR) system or by speaking to a billing services representative.

3. Pay by mail

- a. Send a check or money order to the address listed on your billing invoice payment coupon. **Be sure to mail your payment at least seven to 10 days prior to your premium payment due date. Remember to write your member ID number on the check or money order and detach the payment coupon from the billing invoice and mail with your payment.**
- b. Mailing to the correct address will ensure your payments are processed in a timely manner.

Ambetter from SilverSummit Healthplan

Attn: Billing Services

PO Box 748737

Los Angeles, CA 90074-8737





We Care About Your Health

How Can I Pay My Monthly Premium?

(Continued)

- c. To find a MoneyGram location near you, or to make an Ambetter payment with MoneyGram go to <https://www.moneygram.com/mgo/us/en/paybills> or call 1-800-926-9400.

What Happens If I Pay Late?

Your bill is due before the first day of every month. For example, if you are paying your premium for June, it will be due May 31.

If you don't pay your premium before its due date, you may enter a grace period. This is the extra time we give you to pay. During a grace period, we may hold — or pend — payment of your claims. During your grace period, you will still have coverage. However, if you don't pay before a grace period ends, you run the risk of losing your coverage. Refer to your *Evidence of Coverage* for grace period details.

Member Services

We want you to have a great experience with Ambetter. Our Member Services Department is always here for you. We can help you:

- Understand how your plan works
- Learn how to get the care you need
- Find answers to any questions you have about health insurance
- See what your plan does and does not cover
- Pick a PCP that meets your needs
- Get more information about helpful programs, like Care Management
- Find other healthcare providers (like in-network pharmacies and labs)
- Request your member ID or other member materials

If you enrolled through the Health Insurance Marketplace you must contact them to: update your enrollment information, such as your date of birth, address or income or life changes; or to end your coverage with Ambetter. You can do this by visiting [Healthcare.gov](https://www.healthcare.gov) or calling 1-800-318-2596 (TTY: 1-855-889-4325). When you are connected, be ready to provide your state and then ask for a representative to help you.

If you are enrolled in an off-exchange plan, please contact Member Services to update your enrollment information, such as your date of birth, address or income or life changes; or to end your coverage with Ambetter.



Have total or partial hearing loss?
Call 1-866-263-8134 (TTY/TDD
1-855-868-4945) or visit
[Ambetter.SilverSummit
Healthplan.com](https://www.Ambetter.SilverSummitHealthplan.com)

Membership & Coverage Information



Your Ambetter Member Welcome Packet

When you enroll with Ambetter, you will receive a Member Welcome Packet. Your Welcome Packet includes basic information about the health plan you selected. You will receive your Welcome Packet once your first month's premium payment is paid in full.

Your Ambetter Member ID

Your member ID is proof that you have health insurance with us. And it's very important. Here are some things to keep in mind:

- Keep this card with you at all times
- You will need to present this card anytime you receive healthcare services
- You will receive your Member ID(s) once your first month's premium payment is paid in full. If you don't get your Member ID before your coverage begins, call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945). We will send you another card.

To download your Digital ID, request a replacement ID or request a temporary ID, please log into your secure member account.

Here is an example of what a member ID typically looks like

| | | | |
|--|---|-------------------------------------|--|
|  FROM  | | IN NETWORK COVERAGE ONLY | |
| Subscriber: [Jane Doe] Member: [John Doe] Policy #: [XXXXXXXXXX] Member ID #: [XXXXXXXXXXXXXXXXXX] Plan: [Ambetter Balanced Care] [Line 2 if needed] [Line 3 if needed] | Effective Date: [XX/XX/XX] RXBIN: [004330] RXPCN: [ADV] GROUP: [RX-5000] Provider Network: [Provider Network Name XXXXXXXXX] | REFERRAL NOT REQUIRED | |
| COPAYS PCP: [\$10 coin. after ded.] Specialist: [\$20 coin. after ded.] Rx (Generic/Brand): [20%/25 after Rx ded.] Urgent Care: [20% coin. after ded.] ER: [\$250 copay after ded.] Individual Deductible INN (Med/Rx): [\$5000/XXXX] OON (Med/Rx): [\$5000/XXXX] | Family Deductible INN (Med/Rx): [\$5000/XXXX] OON (Med/Rx): [\$5000/XXXX] Individual MOOP INN: [XXXXXXXXXX] Individual MOOP OON: [XXXXXXXXXX] Family MOOP INN: [XXXXXXXXXX] Family MOOP OON: [XXXXXXXXXX] Coinurance (Med/Rx): [50%/30%] | | |

Front

| | |
|---|---|
| [Ambetter.SilverSummitHealthplan.com] | |
| [Member/Provider Services: 1-866-263-8134 TTY/TDD: 1-855-868-4945 24/7 Nurse Line: 1-866-263-8134 | [Medical Claims: SilverSummit Healthplan Attn: CLAIMS PO Box 5000 Farmington, MO 63630-5010 |
| Numbers below for providers: Pharmacy Help Desk: 1-844-345-2835 EDI Payor ID: 09069 | |
| <small>[Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.SilverSummitHealthplan.com.]</small> | |
| <small>AMB21-NV-C-00609 [Ambetter from SilverSummit Healthplan is underwritten by SilverSummit Healthplan, Inc. © 2021 SilverSummit Healthplan, Inc. All rights reserved.]</small> | |

Back

Refer to your *Evidence of Coverage* for information on Dependent Member Coverage.

We're proud to offer our quality service. Our local provider network is the group of

Finding the Right Care



doctors, hospitals and other healthcare providers who have agreed to provide you with your healthcare services.

To search our online Provider Directory, visit guide.ambetterhealth.com and use our **Ambetter Guide- the new Ambetter provider search tool**. This guide will have the most up-to-date information about our provider network, including information such as name, address, telephone numbers, hours of operation, professional qualifications, specialty, and board certification. It can help you find a primary care provider (PCP), pharmacy, lab, hospital or specialist. You can narrow your search by:

- Provider specialty
- ZIP code
- Gender
- Languages spoken
- Whether or not they are currently accepting new patients

A Provider Directory is a listing of providers near you. If you would like a printed copy of this listing, please call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

In-Network or Network Provider means a physician or provider who is identified in the most current list for the network shown on your Member ID.

Out-of-Network or Non-Network Provider means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage* (EOC).

Throughout the year, the provider's available in-network may change. It is important that you review the provider directory for the latest information on whether or not the provider you are planning to see is in-network. We encourage you to ask the providers if they participate with Ambetter before they treat you, so you know whether you may receive an additional bill for their services.



Remember to select an in-network PCP! Check out our *Provider Directory* for a full list of your options and their contact information. It's on the **Find a Doctor** page of guide.ambetterhealth.com.

Refer to your *Evidence of Coverage* for more information on your Provider Directory.



Every time you receive care, make sure to stay within the Ambetter network.

Get The Right Care At The Right Place

When you need medical care, you need to be able to quickly decide where to go or what to do. Get to know your options! They include

1. **Calling our 24/7 nurse advice line**
2. **Ambetter Telehealth**
3. **Making an appointment with your primary care provider (PCP)**
4. **Visiting an urgent care center**
5. **Going to the emergency room (ER)**

Your decision will depend on your specific situation. The next section describes each of your options in more detail, so keep reading.

And remember — always make sure your providers are in-network.

Using in-network providers can save you money on your healthcare costs.

Every time you receive medical care, you will need your member ID.

Learn more about your options <https://Ambetter.SilverSummitHealthplan.com/resources/handbooks-forms/where-to-go-for-care.html>



Your Primary Provider (PCP)

Your primary care provider is your main doctor — the one you see for regular checkups. If your condition isn't life-threatening, calling your PCP should be your first choice. Use our online Ambetter Guide to find an in-network provider in your area.

Visit or call your PCP if you need:

- Your annual wellness checkup & vaccinations
- Advice about your overall health
- Help with medical problems such as cold, the flu and fevers
- Treatments for an ongoing health issue like asthma or diabetes

Selecting A Different PCP

We want you to be happy with the care you receive from our providers. So if you would like to change your PCP for any reason, visit Ambetter.SilverSummitHealthplan.com. Log in to your online member account and follow these steps

- 1. Click on Coverage or Edit Account**
- 2. Under the My Primary Care Provider section, pull up the Ambetter Guide to search for an in-network PCP.**
- 3. Pick a PCP from the list. Make sure you select a PCP who is currently accepting new patients.***

To learn more about a specific PCP, call 1-866-263-8134 (TTY/TDD 1-855-868-4945). You can also visit Ambetter.SilverSummitHealthplan.com to see our provider list on our **Find a Doctor** web page.

**If you choose a nurse practitioner or physician assistant as your PCP, your benefit coverage and co-payment amounts are the same as they would be for services from other participating providers. Review your Schedule of Benefits for more information.*



Call our 24/7 nurse advice line anytime: 1-866-263-8134 (TTY/TDD 1-855-868-4945).

When To Go To An Urgent Care Center

An urgent care center provides fast, hands-on care for illnesses or injuries that aren't life threatening but still need to be treated within 24 hours. Typically, you will go to an urgent care center if your PCP cannot get you in for a visit right away.

Common urgent care issues include:

- Sprains
- Ear infections
- High fevers
- Flu symptoms with vomiting

If you think you need to go to an urgent care center, follow these steps:

- Call your PCP. Your PCP may give you care and directions over the phone or direct you to the right place for care.
- If your PCP's office is closed, you can do one of two options:
 1. Locate an in-network urgent care center by using our online Ambetter Guide at [Guide.AmbetterHealth.com](https://www.AmbetterHealth.com), type in "Urgent Care" and your zip code, then click search.
 2. Call our 24/7 nurse advice line at 1-866-263-8134 (TTY/TDD 1-855-868-4945). A nurse will help you over the phone or direct you to other care. You may have to give the nurse your phone number.

Check your *Schedule of Benefits* to see how much you must pay for urgent care services.

After your visit, let your PCP know you were seen at an urgent care and why.

When To Go To The ER

Anything that could endanger your life (or your unborn child's life, if you're pregnant) without immediate medical attention is considered an emergency situation. Emergency services treat accidental injuries or the onset of what appears to be a medical condition. We cover emergency medical and behavioral health services both in and out of our service area. We cover these services 24/7. Emergency services are covered in-network and out-of-network. When receiving Emergency Care at either an in-network or out-of-network provider the only bill you should receive is for any applicable cost share. (e.g. co-pay, deductible or co-insurance).

Refer to your *Evidence of Coverage* for information on Protection from Balance Billing.



Have your member ID and photo ID ready. You will need them whenever you receive any type of care.

Urgent care is not emergency care. Only go to the ER if your doctor tells you to or if you have a life-threatening emergency.



Always make sure your providers are in-network. Using in-network providers can save you money on your healthcare costs.



If you need help deciding where to go for care, call our 24/7 nurse advice line at 1-866-263-8134 (TTY/TDD 1-855-868-4945). In an emergency, call 911 or head straight to the nearest emergency room. Seek ER services only if your life is at risk and you need immediate, emergency medical attention.

When To Go To The ER (Continued)

Go to the ER if you have:

- Broken bones
- Bleeding that won't stop
- Labor pains or other bleeding (if you're pregnant)
- Severe chest pains or heart attack symptoms
- Overdosed on drugs
- Ingested poison
- Bad burns
- Shock symptoms (sweat, thirst, dizziness, pale skin)
- Convulsions or seizures
- Trouble breathing
- The sudden inability to see, move or speak
- Gun or knife wounds

Don't go to the ER for:

- Flus, colds, sore throats or earaches
- Sprains or strains
- Cuts or scrapes that don't require stitches
- More medicine or prescription refills
- Diaper rash

What if you need Emergency Care out of our service area?

Our plan will pay for emergency care while you are out of the county or state. If you go to an out-of-network ER and you aren't experiencing a true emergency, you may be responsible for any amounts above what your plan covers. Those additional amounts could be very large and would be in addition to your plan's cost sharing and deductibles.

Learn more about your options <https://Ambetter.SilverSummitHealthplan.com/resources/handbooks-forms/where-to-go-for-care.html>

Ambetter Telehealth

Ambetter Telehealth is our 24-hour access to in-network healthcare providers when you have a non-emergency health issue. It's available to use when you're at home, in the office or on vacation.

Before you start using Ambetter Telehealth, you will need to set up your account at [AmbetterTelehealthNV.com](https://www.AmbetterTelehealthNV.com).

Ambetter Telehealth providers are available by phone or video when you need medical care, a diagnosis or a prescription. As part of our Health Management Program, Ambetter offers \$0 copay for in-network Telehealth providers. You can choose to receive immediate care or schedule an appointment for a time that fits in your schedule.

Contact Ambetter Telehealth for illnesses such as:

- Colds, flu and fevers
- Rash, skin conditions
- Sinus problems, allergies
- Upper respiratory infections, bronchitis
- Pink Eye

Ambetter does not provide medical care. Medical care is provided by individual providers through Teladoc Health.

\$0 Telehealth copay does not apply to plans with HSA until the deductible is met. \$0 copays are for in-network medical care. Ambetter does not provide medical care.

24/7 Nurse Advice Line

Our free [24/7 nurse advice line](#) makes it easy to get answers to your health questions. You don't even have to leave home! Staffed by licensed nurses, our 24/7 nurse advice line runs all day, every day. Call 1-866-263-8134 (TTY/TDD 1-855-868-4945) if you have questions about:

- Your health, medications or a chronic condition
- Whether you should go to the emergency room (ER) or see your PCP
- What to do for a sick child
- How to handle a condition in the middle of the night
- Accessing our online health information library
- Urgent care



To find another provider or specialist in our network, check out our provider list on the **Find a Doctor** page at [guide.ambetterhealth.com](https://www.guide.ambetterhealth.com).



WHAT TO DO IF YOU RECEIVE A BILL FROM A PROVIDER OR PHYSICIAN:

When seeing an in network provider, including but not limited to physicians, hospitals, pharmacies, facilities and health care professionals, you are responsible for any applicable cost sharing amounts (e.g. co-pay, deductible or co-insurance). Your member responsibility can be viewed on the explanation of benefits. This can be found by logging into your secure account at Ambetter.SilverSummitHealthplan.com.

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

- You receive a covered emergency service or air ambulance service from a non-network provider. This includes services you may get after you are in stable condition, unless the non-network provider obtains your written consent to bill you for their service.
- You receive non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services)) from a non-network provider at a network hospital or network ambulatory surgical facility.
- You receive other non-emergency services from a non-network provider at a network hospital or network ambulatory surgical facility, unless the non-network provider obtains your written consent to bill you for their service.

If you receive a bill for services in the above situations, please contact Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

Refer to your *Evidence of Coverage* for information on Balance Billing and Eligible Service Expenses.

Member Complaints, Grievances, & Appeals Process



We have steps for handling any problems you may have. To keep you satisfied, we provide processes for filing appeals or complaints. You have the right to file a complaint, file an appeal, and right to an external review.

If You're Not Happy With Your Care

We hope you will always be happy with our providers and us. But if you aren't, or you aren't able to find answers to your questions, we have steps for you to follow:

- Inquiry Process
- Complaint Process
- Grievance Process
- Appeal Process
- External review by an independent review organization (IRO)
- Complaint to the state Department of Insurance (DOI)

Your satisfaction is very important to us. We want to know your issues and concerns so we can improve our services. Please contact our Member Services team at 1-866-263-8134 (TTY/TDD 1-855-868-4945) if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

The following processes are available to address your concerns.

How to Make an Inquiry

An Inquiry is a request for clarification of a benefit, product, or eligibility where no expression of dissatisfaction was made. Examples of an Inquiry could be:

- "Can I make a payment?"
- "Can you help me change my Primary Care Provider?"
- "Why did I receive this bill?"
- "Why did my premium change?"
- "Can I get a copy of my ID?"
- "Can you help me find a Provider?"

How To File A Complaint

A complaint can be an appeal or a grievance. Some complaints can be resolved by first calling Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

Examples of a Complaint could be:

- "I can't get an appointment with the doctor for 4 months"
- "I can't find a provider in my area, as the local doctors are all stating they are not participating with my plan and the ones participating with my plan are too far away"
- "I've called Member Services multiple times and my issue is still not resolved"



How To File A Complaint (Continued)

- “I can’t get enrolled on your website”
- “I can’t find what I am needing on your website”
- “The doctor and/or the staff were rude to me”

To file a complaint, call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

How to File a Grievance

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. Providing of services.
2. Determination to rescind a policy.
3. Claims practices.

Examples of a Grievance would be:

- “My generic prescription didn’t have the generic co-pay applied”
- “I had a preventive procedure and they are making me pay out of pocket, when it should have been covered at 100%”
- “I’m in need of home healthcare and I haven’t gotten a call back from my Case Coordinator”
- “I did not consent to blood products during surgery but found out they gave me some anyway”
- “My doctor prescribed a medication that I’m allergic to and I’ve had a terrible reaction”
- “I was told that I was active with the plan, and the plan kept taking premiums out automatically, but now they are going back and saying I had no coverage for 10 months, and now I have over \$100,000.00 in hospital bills”

To file a grievance, call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945). You may file a grievance, verbally, or in writing, either by mail or by facsimile (fax). If you require assistance in filing a grievance or if you are unable to submit the grievance in writing, you can call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945) to ask for help through the process. We will send a Grievance Acknowledgment letter after receipt of your Grievance.

Send your written Grievance form to:

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

Expedited Grievance: If your grievance concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, or if a standard resolution process will risk serious jeopardy to your life or health.

For a full list of definitions, please refer to your *Evidence of Coverage*.



View your *Evidence of Coverage* for full complaint and appeal procedures and processes. You can access your *Evidence of Coverage* in your online member account.

For a full list of definitions, please refer to your *Evidence of Coverage*.

How to File a Grievance (Continued)

Standard Grievance: A grievance that does not meet the Expedited definition.

View your *Evidence of Coverage* for full complaint procedures and processes, including specific filing details and timeframes. You can access your *Evidence of Coverage* in your online member account.

You may also file a Grievance with the Department of Insurance (DOI). There are several ways to file a Grievance with the DOI. Refer to your *Evidence of Coverage* for more information.

How To File An Appeal

An Appeal is a request to reconsider a decision about the member's benefits where either a service or claim have been denied. A denial includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility.

Examples of an Appeal would be:

1. Access to healthcare benefits, including an Adverse Determination made pursuant to utilization management;
2. Admission to or continued stay in a healthcare Facility;
3. Claims payment, handling or reimbursement for healthcare services;
4. Matters pertaining to the contractual relationship between a Member and us;
5. Cancellation of your benefit coverage by us;
6. Other matters as specifically required by state law or regulation

To file a written appeal, you can mail or Fax your request to us. Our contact information is below:

SilverSummit Healthplan

Attn: Appeal Department
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128
Fax: 1-855-742-0125

To file a verbal appeal, you can call us at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

Resolution timeframes may vary based on the type of appeal filed. Please see *Evidence of Coverage* for details.

Expedited Appeal: If your appeal concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, or if you believe a standard resolution process will risk serious jeopardy to your life or health.

Standard Appeal: An appeal that does not meet the Expedited definition.

You may have the right to have an independent review of certain final decisions made by Ambetter From SilverSummit. If you request it, an appeal will be conducted by an independent review organization (IRO). An IRO is not



How To File An Appeal (Continued)

connected in any way with Ambetter From SilverSummit, and we must abide by the IRO's decision and carry out its instructions.

If you are dissatisfied with the decision, you may make an appeal over the phone or in writing by contacting:

Office for Consumer Health Assistance (OCHA)

555 East Washington #4800
Las Vegas, NV 89101
(702) 486-3587 or (888)333-1597
Fax (702)486-3586

Continued Coverage During An Appeal

If we are going to reduce or stop a service we had previously approved and the time limit we have approved has not ended, you have the right to request to keep getting the service until:

- The end of the approved treatment period

OR

- The determination of the appeal

You may be financially responsible for the continued services if your appeal is not approved.

You can request continued services by calling Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

NOTE: You can't request an extension of services after the original authorization has ended. For more details, call Member Services at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

View your *Evidence of Coverage* for full complaint and appeal procedures and processes, including specific filing details and timeframes. You can access your *Evidence of Coverage* in your online member account.

What Is Utilization Management?

We want to make sure you get the right care and services. Our utilization management (UM) process is designed to make sure you get the treatment you need.

We will approve all covered benefits that are medically necessary. Our UM Department checks to see if the service needed is a covered benefit. If it is a covered benefit, the UM nurses will review it to see if the service requested meets medical necessity criteria. They do this by reviewing the medical notes and talking with your doctor. Ambetter does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities. UM's decision making is based only on appropriateness of care, services, and existence of coverage. Ambetter from SilverSummit Healthplan does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

What Is Utilization Review?

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

Preservice or prior authorization review

Ambetter may need to approve medical services before you receive them. This process is known as prior authorization. Prior authorization means that we have pre-approved a medical service.

To see if a service requires prior authorization, check with your PCP, the ordering provider, or Ambetter Member Services. When we receive your prior authorization request, our nurses and doctors will review it. If prior authorization is not received on a medical service when required, you may be responsible for all charges.

Concurrent review

Concurrent utilization review evaluates your services or treatment plans (like an inpatient stay or hospital admission) as they happen. This process determines when treatment may no longer be medically necessary. It includes discharge planning to ensure you receive services you need after your discharge from the hospital.

Retrospective review

Retrospective review takes place after a service has already been provided. Ambetter may perform a retrospective review to make sure the information provided at the time of authorization was correct and complete. We may also evaluate services you received due to special circumstances (for example, if we didn't receive an authorization request or notification because of an emergency).

Notification of Approved Services

All claims information (including prior authorizations) can be found by logging into the member secure portal and selecting the activity and usage link.



What Is Utilization Review? (Continued)

Adverse determinations and appeals

An adverse determination occurs when a service is not considered medically necessary, appropriate, or because it is experimental or investigational. You will receive written notification to let you know if we have made an adverse determination. In the notice, you will receive detailed information about why the decision was made, as well as the process and time frame you should follow for submitting appeals.

Member Resources & Rewards



Visit us online at
Ambetter.SilverSummitHealthplan.com

Our website helps you get the answers you need to get the right care, the right way, including an online member account for you to check the status of your claim, view your *Evidence of Coverage (EOC)* or understand your out-of-pocket costs, copays and progress towards meeting your annual deductible.

Get Online And Get In Control

Did you know you can always access helpful resources and information about your plan? It's all on our website! Visit Ambetter.SilverSummitHealthplan.com and take charge of your health.

On our website, you can:

- Find a PCP
- Locate other providers, like a pharmacy
- Find health information
- Learn about programs and services that can help you get and stay healthy.

Log into your online member account to:

- Pay your monthly bill
- Print a temporary ID or request a replacement ID
- View your claims status and payment information
- Change your PCP
- Find pharmacy benefit information
- Send us a secure email
- Read your member materials (your *Evidence of Coverage*, *Schedule of Benefits*, this QRG)
- Participate in the *myhealthpays*[®] rewards program
- Complete your Wellbeing Survey
- Contact a nurse online
- Review out-of-pocket costs, copays and progress towards deductibles.

myhealthpays[®] Rewards Program

Don't miss out on the exciting *myhealthpays*[®] program and start earning points today!

Log in now and activate your account to start earning more rewards.

1. Log into your online [Ambetter member account](https://Ambetter.SilverSummitHealthplan.com) or create your account now.
2. Click Rewards on the home page.
3. Accept Terms & Conditions. Then, start earning points!

If you already activated your account, log back in to complete healthy activities and keep earning!

Funds expire immediately upon termination of insurance coverage.

Connecting Your Healthcare:



NEW OPTIONS FOR MANAGING YOUR DIGITAL MEDICAL RECORDS

Starting July 1, 2021, a new federal rule named the Interoperability and Patient Access rule (CMS-915-F) made it easier for Ambetter members to access their health information when they need it most. You will now have complete access to your health information on your mobile device which will allow you to manage your health better and know what healthcare resources are available to you.

Imagine:

- You go to a new healthcare provider because you don't feel well and pulling up your health history from the past five years on your mobile device.
- Finding a provider or specialist by checking an up-to-date provider directory who can use your health history to diagnose you and ensure you receive the best care you can.
- You have a question about a claim, so you go to your computer and see if it's paid, denied, or still being processed.
- Taking your health history data, at your request, with you as you move between health plans.*

**Beginning January 1, 2022, members will have this ability to request that their health information be transferred with them as they move between health plans.*

THE NEW RULE MAKES IT SO YOU CAN EASILY FIND INFORMATION** ON:

- Claims (paid and denied)
- Specific parts of your clinical information
- Pharmacy drug coverage
- Healthcare providers

***Information is available for dates of service on or after January 1, 2016*

For more information, visit your Ambetter online member account.

Your Healthcare Glossary

We know that health insurance can feel confusing sometimes. To help you out, we put together a list of words you may need to know as you read through this QRG. Check it out!

Adverse Determination Notice

This is the notice you receive if we deny coverage for a service you have requested.

Appeal

An Appeal is a request to reconsider a decision about the member's benefits where either a service or claim have been denied. A denial includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. Failure to approve or deny a prior authorization request timely may be considered as a denial and also subject to the appeal process.

Balance Billing

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

Complaint

A complaint can be an appeal or a grievance. Some complaints can be resolved through first call resolution if they can be fully addressed and closed.

Copay or Copayment

The set amount of money you pay every time you receive a medical service or pick up a prescription.

Emergency Care/Emergencies

Emergency care is care that you receive in an emergency room (ER). Only go to the ER if your life is at risk or you need immediate, emergency medical attention.

Evidence of Coverage

The document that lists all of the services and benefits that your particular plan covers. Your *Evidence of Coverage* has information about the specific benefits covered and excluded under your health plan. Read through your *Evidence of Coverage* — it can help you understand exactly what your plan does and doesn't cover.

Grievance

Any complaint about quality of service or medical care is a grievance, including dissatisfaction with the quality of medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

For a full list of complete definitions, please refer to your *Evidence of Coverage*.



Your Healthcare Glossary (Continued)

In-Network (Providers and/or Services)

The Ambetter network is the group of providers and hospitals we partner with to provide care for you. If your provider or service is within our network, it is covered on your health plan. If a provider or service is out-of-network, you could be responsible for services you receive. When possible, always stay in-network.

Inquiry

A request for clarification of a benefit, product, or eligibility where no expression of dissatisfaction was made.

Out-of-Network Provider

Means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage* (EOC). Refer to your *Evidence of Coverage* for details regarding out-of-network providers, care, services and expenses.

Premium Payment

Your premium is the amount of money you'll pay every month for health insurance coverage. Your monthly bill shows your premium payment.

Preventive Care Services

Preventive care services are regular healthcare services designed to keep you healthy and catch problems before they start. For example: your checkups, blood pressure tests, certain cancer screenings and more. A list of Preventive Care services can be found within your *Evidence of Coverage*, as well as on our website at Ambetter.SilverSummitHealthplan.com.

Primary Care Provider (PCP)

Your PCP is the main doctor you will see for your healthcare needs. Get to know your PCP well and always stay up-to-date with your well-visits. The better your PCP knows your health, the better they are able to serve you.

Prior Authorization

Prior authorization may be required for covered services. When a service requires prior authorization, then the covered service needs to be approved before you visit your provider. Your provider will need to submit a prior authorization request.

Schedule of Benefits

Your *Schedule of Benefits* is a document that lists covered benefits available to you. Your *Schedule of Benefits* has information about your specific copayment, cost sharing and deductible amounts for covered benefits.

Subsidy

A subsidy is a tax credit that lowers your monthly premium. Subsidies come from the government. Whether or not you qualify for one depends on your family size, your income and where you live.

Urgent Care

Urgent care is medical care that you need quickly. You can get urgent care at an urgent care center.



Your Healthcare Glossary (Continued)

Utilization Management

This is the process we go through to make sure you get the right treatment. We review your medical and health circumstances and then decide the best course of action.

Ambetter from SilverSummit Healthplan is underwritten by SilverSummit Healthplan, Inc.

© 2022 SilverSummit Healthplan, Inc.

All rights reserved.

AMB21-NV-C-00632_CORE

Statement of Non-Discrimination

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

Ambetter from SilverSummit Healthplan:

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

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

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

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

