silversummit healthplan™

2022 Member Handbook

SilverSummitHealthplan.com • 1-844-366-2880 • TDD/TTY: 1-844-804-6086

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Thank you for choosing SilverSummit Healthplan as your health plan!

SilverSummit Healthplan works with the Nevada Department of Health and Human Services (DHHS), and the Division of Healthcare Financing and Policy (DHCFP). We provide health services for the Nevada Medicaid and Nevada Check Up program. With your doctor, we help manage your care and health. Our job is to make sure you get the services you need to stay healthy.

WHAT IS THE NEVADA MEDICAID AND NEVADA CHECK UP PROGRAM?

Nevada Medicaid and Nevada Check Up are the names of programs that serve Medicaid recipients enrolled in Nevada's Medicaid managed care program. Their mission is to provide low-cost, comprehensive healthcare coverage to low income adults and, uninsured children (birth through age 18) who are not covered by private insurance while also focusing on the following:

1. Promoting healthcare coverage for your child;
2. Encouraging individual responsibility; and
3. Working with public and private healthcare providers and community advocates for children.

WHO IS SILVERSUMMIT HEALTHPLAN?

SilverSummit Healthplan is a Medicaid Managed Care Organization (MCO). Usually this is called an "MCO." A "member" is anyone who gets services from the MCO. The purpose of an MCO is to give members access to all of the health services they need through one company.

As an MCO, SilverSummit Healthplan will help coordinate your unique healthcare needs. By doing this, our goal is to improve health outcomes for every Nevadan we have the privilege to serve.

You may contact us to request any information about SilverSummit Healthplan. You can get information about:

- How we work with your other health plans (if you have one)
- How we pay our providers
- Results of member surveys
- How many members decide not to use SilverSummit Healthplan
- Benefits, eligibility, claims or participating providers

If you want to tell us ways to improve or recommend changes in our policies, procedures or services, please call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Welcome

ABOUT YOUR MEMBER HANDBOOK

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE VENDOR AND THE RECIPIENT.

We update our member handbook once a year. If we make any changes to the member handbook, we will notify you at least 30 days prior to making the changes. You may request a copy of our member handbook annually or as needed. The Member Handbook is a detailed guide to SilverSummit Healthplan and your healthcare benefits. It is our contract with you. The Member Handbook explains your rights, your benefits and your responsibilities as a member of SilverSummit Healthplan. Please read this booklet carefully. It gives you information on your benefits and services:

- What is covered/not covered by SilverSummit Healthplan
- How to get the care you need
- Your rights and responsibilities
- How to get your prescriptions filled
- How to choose your Primary Care Provider (PCP)
- What to do if you are unhappy about your health plan or coverage
- Eligibility requirements
- When to use Urgent Care instead of the Emergency Room
- Materials you will receive from Silver Summit Healthplan

Call Member Services at 1-844-366-2880 to receive an additional copy of the Member Handbook at no cost to you. You may also visit our website at **SilverSummitHealthplan.com** to view the Member Handbook.

Please take time to look over your handbook. Keep it handy in case you need it.

OTHER FORMATS AND LANGUAGES

For members who do not speak English or do not feel comfortable speaking it, SilverSummit Healthplan has a free service to help. This service is very important because you and your doctor must be able

to talk about your health concerns in a way you both can understand. Our interpreter services are provided at no cost to you and can help with many different languages. This includes sign language. SilverSummit Healthplan members who are blind or visually impaired can call Member Services for an oral interpretation. To arrange for interpretation services, call Member Services 1-844-366-2880 (TDD/ TTY 1-844-804-6086).

If you would like this handbook in large print, Braille, audio CD, in a different language or another format, please call Member Services.

La información incluida en este folleto es acerca de sus beneficios del Plan de Salud SilverSummit

Healthplan. Si necesita obtener la información en un idioma diferente, llame al Departamento de Servicios para Miembros al 1-844-366-2880, TTY: 1-844-804-6086, Rele' 711.

TRANSLATIONS AND INTERPRETER SERVICES

Translation and interpreter services are available. There is no cost for these services. This includes sign language. We can help you talk with your doctors and other healthcare providers when you do not have another translator available.

SilverSummit Healthplan has a telephone language line available any time. To request an interpreter, call Member Services. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. You can tell us the language you speak, and we will get an interpreter. They can be on the phone to help you call your healthcare provider. Or, we can have an interpreter available at your appointment.

You can get an interpreter when we are not open. Talk to the Nurse Advice Line option. We will make sure that you are connected.

We will interpret or translate any of our member documents into your preferred language. Just call us and tell us the language you need.

Servicios de Intérprete

Los servicios de interpretación se proporcionan sin costo para usted. Esto incluye lenguaje de señas. Además incluye interpretación oral en tiempo real. SilverSummit Healthplan tiene una línea telefónica para idiomas disponible las 24 horas del día, los siete días de la semana. Le podemos ayudar a conversar con sus médicos y otros proveedores de atención médica cuando no se encuentra disponible otro traductor.

Vamos a traducir nuestros materiales para miembros en su idioma preferido a petición. Para solicitar un intérprete: Llame a Servicios para los miembros al 1-844-366-2880, TTY: 1-844-804-6086, Rele' 711 y

díganos qué idioma habla. Nos aseguraremos de que haya un intérprete en el teléfono con usted cuando llame a su proveedor de atención médica, o que esté disponible en su cita.

Marketplace Plan: 1-866-263-8134 (TTY/TDD 1-855-868-4945)
Medicaid Plan: 1-844-366-2880 (TTY/TDD 1-844-804-6086)

English: Language assistance services, auxiliary aids and services, and other alternative formats are available to you free of charge. To obtain this, please call the number above.

Español (Spanish): Servicios de asistencia de idiomas, ayudas y servicios auxiliares, y otros formatos alternativos están disponibles para usted sin ningún costo. Para obtener esto, llame al número de arriba.

Tagalog (Tagalog): Mayroon kang makukuhang libreng tulong sa wika, auxiliary aids at mga serbisyo, at iba pang mga alternatibong format. Upang makuha ito, mangyaring tawagan ang numerong nakasulat sa itaas.

简体中文**(Chinese)**：可以免费为您提供语言协助服务、辅助用具和服务以及其他格式。如有需要，请拨打上述电话号码。

한국어(Korean): 언어 지원 서비스, 보조적 지원 및 서비스, 기타 형식의 자료를 무료로 이용하실 수 있습니다. 이용을 원하시면 상기 전화번호로 연락해 주십시오.

Tiếng Việt (Vietnamese): Các dịch vụ trợ giúp ngôn ngữ, các trợ cụ và dịch vụ phụ thuộc, và các dạng thức thay thế khác hiện có miễn phí cho quý vị. Để có được những điều này, xin gọi số điện thoại nêu trên.

አማርኛ (Amharic):- ከክፍያ ነጻ የቋንቋ ድጋፍ አገልግሎቶች፣ ተቀጽላ እርዳታዎች እና አገልግሎቶች፣ እና ሌሎች አማራጭ ቅርጸቶች ያገኛሉ። ይህን ለማግኘት እባክዎን ከላይ ባለው ቁጥር ይደውሉ።

ไทย (Thai): บริการช่วยเหลือด้านภาษา อุปกรณ์และบริการเสริม รวมทั้งรูปแบบทางเลือกอื่น ๆ มีให้ท่านใช้ได้โดยไม่เสียค่าใช้จ่าย หากต้องการขอรับบริการเหล่านี้ กรุณาติดต่อทางโทรศัพท์ที่หมายเลขข้างต้น

日本語 **(Japanese):** 言語支援サービス、補助器具と補助サービス、その他のオプション形式を無料でご利用いただけます。ご利用をお考えの方は、上記の番号にお電話ください。

العربية (Arabic) : خدمات المساعدة اللغوية والمعينات والخدمات الإضافية وغيرها من الأشكال البديلة متاحة لك مجانا. للحصول عليها، يرجى الاتصال بالرقم أعلاه.

Русский язык (Russian): Вам могут быть бесплатно предоставлены услуги по переводу, вспомогательные средства и услуги, а также материалы в других, альтернативных, форматах. Чтобы получить их, позвоните, пожалуйста, по указанному выше номеру телефона.

Français (French) : Des services gratuits d’assistance linguistique, ainsi que des services d’assistance supplémentaires et d’autres formats sont à votre disposition. Pour y accéder, veuillez appeler le numéro ci-dessus.

فارسي (Persian): خدمات ترجمه، حمایت های ؛ خدمات کمکی و سایر انواع دیگر به صورت رایگان در اختیار شما قرار می گیرند. برای به دست یابي به این خدمات، لطفا با شماره تلفن بالا تماس بگیرید.

Samoan (Samoan): Auaunaga e lagolago i lau gagana, auaunaga fesoasoani atu, ma isi auaunaga e maua fua atu e leai se totogi. Pe a mana’omia ia auaunaga, vili le numera o loo tāua i luga.

Deutsch (German): Sprachunterstützung, Hilfen und Dienste für Hörbehinderte und Gehörlose sowie weitere alternative Formate werden Ihnen kostenlos zur Verfügung gestellt. Um eines dieser Serviceangebote zu nutzen, wählen Sie die o. a. Rufnummer.

Ilokano (Ilocano): Makaala kayo iti libre nga tulong para iti serbisyo nga kasapulan maipanggep iti lengguwahe, dadduma nga tulong ken serbisyo, umawag kayo laeng iti numero nga adda iti ngato.

Important Contacts

YOUR PERSONAL CONTACTS

Your Primary Care Provider: ____

Your nearest urgent care clinic: ____

CONTACTING SILVERSUMMIT HEALTHPLAN

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

Member Services and 24/7 free Nurse Advice Line 1-844-366-2880

TTY...1-844-804-6086

Relay 711

Fax 1-866-694-3734

We are open Monday through Friday 8:00 a.m. to 5:00 p.m. PT. The Nurse Advice Line is available any time!

OTHER IMPORTANT PHONE NUMBERS

In an emergency...Call 911

Medicaid Recipient Customer Service

Las Vegas Medicaid District Office..1-702-668-4200

Reno District Office 1-775-687-1900

Live peer coaches are also available right now, please call
Community Connections Hotline 1-866-775-2192

MEMBER SERVICES CAN HELP

SilverSummit Healthplan Member Services helps you with questions about your plan. Our Member Services team is located in Las Vegas, Nevada. They are available by phone, mail, fax and email.

If you have questions or if you need help understanding something, please call us. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. We have a team of people ready to help you.

We can help you in many ways:

- Find a doctor or other provider
- Get a new SilverSummit Healthplan member identification (ID) card
- Understand covered and non-covered benefits
- File a grievance or appeal
- Request a List of Providers or Member Handbook
- Report possible fraud issues by a member or provider
- Change your address and phone number
- Receive new member materials

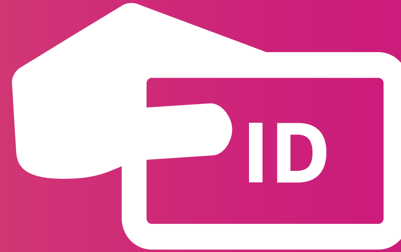
We are open Monday through Friday from 8:00 a.m. to 5:00 p.m. PT. We are closed on most Nevada state holidays.

We have a secure member portal on our website **SilverSummitHealthplan.com**. You can use it to send us emails. Our fax number is 1-866-694-3734. You can also mail information to us. The address is:

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

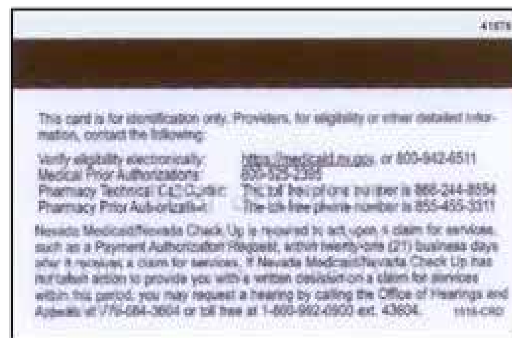
SilverSummit Healthplan will tell you about important changes. When there is a change, we will send you a letter at least 30 days before this change occurs.

How Your Health Plan Works



YOUR MEMBER ID CARD

When you enroll, you will receive a Medicaid card and a SilverSummit Healthplan card. Bring both ID cards to all appointments. DHHS will mail you a blue Nevada Medicaid ID card. Your Medicaid card will look like this:



silversummit healthplan.

NAME: JANE DOE
MEDICAID ID#: XXXXXXXXXXX

PCP NAME: JANE DOE
PCP NUMBER: XXXXXXXXXX
AFTER HOURS #: X-XXX-XXX-XXXX

RX: ENVOLVE PHARMACY SOLUTIONS
RXBIN: 004336
RXPCN: MCAIDADV
RXGRP: RX5462
PHARMACY HELP DESK:
1-844-214-2606

If you have an emergency, call 911 or go to the nearest emergency room (ER).
If you are not sure if you need to go to the ER, call your PCP or SilverSummit's 24/7 nurse advice line. SilverSummitHealthPlan.com
Si tiene una emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Si no está seguro de si necesita ir a la sala de emergencia, llame a su PCP o la línea de consejo de enfermaría de SilverSummit que atiende 24/7. SilverSummitHealthPlan.com

Important Contact Information/ Información Importante De Contacto Members /Miembros:
Member Services/Servicios para los miembros: **1-844-366-2880**
TTY/TDD/Personas con problemas de audición: **1-844-804-6086**
24/7 Nurse Advice Line/Línea de consejo de enfermería 24/7: **1-844-366-2880**
Vision/Vista: **1-855-896-8572** File a Complaint/Presentar un reclamo: **1-844-366-2880**
Community Connections Hotline: **1-866-775-2192**

Medical Claims /Reclamaciones Médicas:
EDI Payer for Medical Claims 68069
SilverSummit Healthplan
Attn: Claims
P.O. Box 5090
Farmington, MO 63640-5050

Provider Services /Servicios para proveedores: 1-844-366-2880
IVR Eligibility Inquiry - Prior Auth / Preguntas de elegibilidad de IVR - Aut. previa:**1-844-366-2880**
Vision/Vista: **1-855-896-8572**

SilverSummit Healthplan address/ Dirección de SilverSummit Healthplan:
2500 North Buffalo Drive, 2nd Floor
Las Vegas, NV 89128

EDI/EFT/ERA please visit Provider Resources at/visite Recursos para proveedores en
SilverSummitHealthPlan.com

The card will be mailed to you within five business days after we are told you are a member. Your member ID card is proof you are a SilverSummit Healthplan member.

Show both ID cards every time you need care:

- Medical appointments
- Urgent care
- Vision appointments
- Behavioral health appointments
- Emergency visits
- Picking up prescriptions from the pharmacy

In addition, you must also keep your Medicaid ID card with you in order to receive Medicaid benefits not provided by SilverSummit Healthplan.

Anytime you receive a new member ID card, please destroy your old one. If you lose your SilverSummit Healthplan member ID card, or did not receive one, we can replace it. Please visit the secure member portal to ask for a new one. Or call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. We will send you a new ID card within 10 days.

You can print a temporary SilverSummit Healthplan member ID card from the secure member portal. Go to our website: **SilverSummitHealthplan.com**.

Keep your cards with you and safe at all times. Make sure they are not stolen or used by someone else. SilverSummit Healthplan coverage is for you only. It is up to you to protect your member ID card. No one else can use your member ID card.

It is against the law to give or sell your member ID card to anyone. If another person uses your card, you may be disenrolled from SilverSummit Healthplan. And the state could charge you with a crime.

24/7 NURSE ADVICE LINE

You can call the SilverSummit Healthplan Nurse Advice Line any time. This service is free and they can answer health questions. They answer calls 24 hours a day, every day. Call 1-844-366-2880, TTY: 1-844-804-6086, Relay 711 with your health question. Have your ID card with you when you call. The nurse will ask for your number.

Our nurses speak English and Spanish. If you speak a different language, you can ask for a translator.

WHAT CAN WE HELP YOU WITH?

- Questions about your health
- Where you can get care
- Understanding how to take your medicine
- Information about your pregnancy
- Information about health conditions

DO YOU HAVE A MEDICAL OR MENTAL HEALTH EMERGENCY?

If you are not sure if you should go to the emergency room, you can call us. Our nurses will help you figure out if you need emergency care, urgent care or if you should see your doctor.

MEMBER CONNECTIONS®

Member Connections can help you get preventive healthcare and services. These are services to help you stay healthy. The Member Connections team is trained to support our members.

They help support members in many ways:

- Find doctors, specialists or other providers
- Find community support services
- Arrange for needed services

Member Connections can also come to your home to assist you. For more information, call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

YOUR COVERED BENEFITS

SilverSummit Healthplan covers many medical services for your healthcare needs. Some services must be prescribed by your doctor. Some services must also be approved by SilverSummit Healthplan before you get the service.

Service	Description and Limits	Prior Authorization Required
Allergy care		Yes, for some services
Ambulance – emergency	Includes ground and emergency helicopter ambulance.	No
Behavioral Health services	Age limitations may apply. Services include crisis stabilization, inpatient psychiatric hospitalization, outpatient assessment and treatment services, residential treatment facilities and rehabilitation services.	Yes, for some services
Breast pumps		Yes
Chiropractic services	Coverage is limited. to members under 21 years of age and referred from Early and Periodic Screening Diagnosis & Treatment (EPSDT) screening by their PCP. Limited to four visits per year.	Yes, after four visits
Durable Medical Equipment (DME)	Items that are not medically necessary, or are not ordered by a provider are not covered.	Yes, in some situations

Service	Description and Limits	Prior Authorization Required
Drugs: prescription/ pharmacy		Yes, for some medications
Drugs: over-the-counter (OTC)	Over-the-counter medications require a doctor's prescription.	No
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/well-child exam	Services are for members age 20 and younger. Well-Child exams, Sports and school physicals annually.	No
Eye care services and eye glasses	Under age 21, one exam every 12 months. Age 21 and older, one exam every 24 months. All members, lenses and frames every 12 months.	No
Family planning	Family planning services can be from any Medicaid doctor or clinic. This includes well-woman exams, screenings and pregnancy testing.	No
Foot care	Routine foot care is not covered. Foot care is covered for children under 21. Foot care visits may be limited. Orthotics are covered for some conditions.	Yes, in some situations
Hearing aids and services		Yes, for cochlear implants
High-risk prenatal and infant services	Care management provides special support for members at risk or with special health needs	Notify plan
Home healthcare	Care must be prescribed by your doctor. And, not able to be received at the hospital or provider's office. Other conditions apply.	Yes
Hospice services	Other than an inpatient facility.	Yes
Immunizations for children	Available to members age 21 and younger.	No
Inpatient and outpatient hospital care	Items that are not medically necessary are not covered.	Yes, including observation services
Maternity care	See your provider as soon as you know you are pregnant. Send us the Notice of Pregnancy (NOP) form at first visit. Prenatal through postpartum services are covered.	
Lab services and testing	Paternity testing and infertility treatment tests are not covered.	Yes, in some situations

Service	Description and Limits	Prior Authorization Required
Nurse midwife services	Covered with all in-network providers.	Yes, for non-participating provider
Obstetric (OB) ultrasounds	Two are allowed per pregnancy unless ordered by perinatologist	Yes, if more than two
Office visits	Covered with all in-network providers.	Yes, for non-participating provider
Orthotics/prosthetics		Yes
Pain management	Not applicable for post-operative pain management.	Yes
Physician services	One routine physical exam every 12 months performed by your PCP. Health visits as needed.	Yes, for non-participating provider
Private duty nursing services	Overnight nursing services and respite care hours are limited.	Yes
Psychiatric hospital service		Yes
Psychiatric services		Yes, for some services
Psychology services		Yes, for some services
Radiology and x-rays	Must be ordered by a provider.	Yes, for high-tech radiology including CT, MRI, MRA
Reconstructive surgery	Surgery that is performed to make you look better and is determined to be cosmetic is not covered.	Yes
Rehabilitation services		Yes
Skilled Nursing Facility care	Items that are not medically necessary are not covered. This includes private rooms or convenience/comfort items.	Yes
Sterilization services	Sterilizations require informed consent forms 30 days prior to the date of procedures. Hysterectomies are covered on a limited basis.	No
Therapy (occupational, physical, speech) services		Yes
Stop smoking/ tobacco cessation	Certain medications, patches or gum to help you stop smoking are covered. Smoking cessation is covered through Tobacco-Free Nevada and National Jewish Health. Call 1-800-QUIT-NOW (784-8669) or 1-844-251-0004 for more information.	No

Service	Description and Limits	Prior Authorization Required
Surgery		Yes, except in an emergency
Transplant services	For Children under 21 years of age, any medically necessary transplant that is not experimental will be covered. For Adults, Corneal, Kidney, Liver and Bone Marrow transplants will be covered if medically necessary.	Yes
Urgent care		No

NOTE: There are some services that your doctor has to get authorization before giving you the care. If you want to know if a service needs authorization, you can call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. There is more information about this later in the handbook. See the "Prior Authorization for Services" section. Some other benefits you can use are telemedicine, telemonitoring and telehealth.

NATIVE AMERICAN ACCESS TO CARE

If you are an American Indian or Alaskan Native, you may choose an Indian Health Service, tribal clinic provider or Urban Indian Health Clinic as your PCP. You may get services from a tribal clinic or Indian Health Services without prior authorization. Or you can go to another SilverSummit Healthplan network provider.

SILVERSUMMIT HEALTHPLAN WEBSITE

Our website will help you get answers about your healthcare. Please visit our website at SilverSummitHealthplan.com. There is information about your benefits and our services. You can get information about several topics:

- Member Handbook
- Provider Directory
- Secure member portal with self-service features
- 24/7 free nurse advice line
- 24/7 mental health and substance use crisis line
- Your privacy rights and responsibilities
- How to report suspected fraud, waste and abuse
- How to find a doctor
- How to file grievances and appeals
- Education on healthy living habits

SECURE MEMBER PORTAL

The SilverSummit Healthplan website has a "Secure Member Portal." You can sign-up and create your own account. Through your account, you can track your health benefits. You can email safely and securely with Member Services.

- The secure member portal gives you access to multiple services:
- Change your Primary Care Provider (PCP)
- Check your rewards balance
- Let us know when you are pregnant so you can get special pregnancy resources
- Let us know about your health by completing a health assessment
- See services you have received
- Email Member Services
- Print a temporary SilverSummit Healthplan member ID card

To Sign Up on the secure member portal, follow these steps:

1. Go to **SilverSummitHealthplan.com**
2. On the homepage, under the heading "For Members" click "Login"
3. Click "Sign Up Now"

Pharmacy Services

When you need prescriptions or over-the-counter (OTC) medication your doctor will give you a prescription. They will contact your pharmacy or give you a written prescription to take to your pharmacy. Then the pharmacy can give you your medicine.

All SilverSummit Healthplan members must use a pharmacy in our network. To find a pharmacy, call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711 or you can look for a pharmacy on our website. The website is **SilverSummitHealthplan.com**.

Show your Nevada Medicaid and SilverSummit Healthplan ID cards to the pharmacy when you pick up medication. Do not wait until you are out of a medication to request a refill. Call your doctor or pharmacy a few days before you run out.

COVERED PRESCRIPTIONS

SilverSummit Healthplan can cover these types of medications:

- Prescription drugs and Over-the-counter (OTC) items approved by the U.S. Food and Drug Administration (FDA) To learn more about covered drugs, please visit **SilverSummitHealthplan.com**.
- Self-injectable drugs (including insulin)
- Drugs to help you quit smoking
- Needles, syringes, test strips, lancets and glucose urine testing strips

NON-COVERED PRESCRIPTIONS

SilverSummit Healthplan does not cover the following prescriptions:

- Drugs that do not have Federal Drug Administration (FDA) approval
- Experimental or investigational drugs
- Drugs to help you get pregnant
- Drugs used for weight loss
- Cosmetic or hair-growth drugs

- Drugs used to treat erectile problems
- Drug Efficacy Study Implementation (DESI) drugs

PREFERRED DRUG LIST(PDL)

Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows some of the drugs that are covered. Not all dosage forms or strengths of a drug may be covered. A team of doctors and pharmacists update this regularly. They want to make sure the medication on the list is safe and helpful for you and that it is cost-effective. Annual updates and major changes in drug coverage and pharmaceutical management edits are communicated to you and your provider by direct mail (e.g. fax, email, mail), as needed.

The preferred drug list includes all drugs available without Prior Authorization (PA) and those agents that have the restrictions of Step Therapy (ST).

A team of doctors and pharmacists update this regularly. They want to make sure the medication on the list is safe and helpful for you and that it is cost-effective. You can find the PDL on the SilverSummit Healthplan website at **SilverSummitHealthplan.com**.

GENERIC DRUGS

Your pharmacist will give you generic drugs when your doctor has approved them. Generic drugs can make healthcare more affordable.

Generic and preferred drugs must be used if they can treat your medical condition. If you cannot use the generic drug, your doctor will have to give a medical reason for you to take a different drug. If generics are not available, you can be given brand-name drugs.

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.

OVER-THE-COUNTER (OTC) DRUG FORMULARY

Some OTC drugs are covered by SilverSummit Healthplan. You will need a prescription from your doctor to have them covered. You can find the Peferred Drug List (PDL) on SilverSummit Healthplan's website at **SilverSummitHealthplan.com**.

As a commitment to our members' overall health and wellbeing, SilverSummit Healthplan offers an additional quarterly benefit of $30 per member household, for commonly used over-the-counter (OTC) items not covered through SilverSummit's pharmacy benefit. These items will be shipped directly to your home from HomeScripts Pharmacy.

Orders may be place via the member portal. For more information or to order by phone, please contact Homescripts at 1-866-577-9010. Hours of availability are Monday to Friday from 8am to 8pm EST. Please have your SilverSummit ID and Medicaid ID available when you call. When ordering, please have the item number ready. A list of OTC items with price can be found on our website at **SilverSummitHealthplan.com**.

PHARMACEUTICAL MANAGEMENT PROCEDURES

SilverSummit Healthplan covers needed drugs for Medicaid members. You may call a Member Service Representative for a list of drugs SilverSummit Healthplan covers.

How do you get your prescriptions?

- Go to your SilverSummit Healthplan doctor for a prescription.
- Go to a pharmacy that is signed up with SilverSummit Healthplan.
- Show them your SilverSummit Healthplan ID card.
- Give them your prescription order. See your Provider Directory for the names of pharmacies near you. Member Services can also help you find a pharmacy. You also can find a pharmacy by using the 'find a Pharmacy' feature in the SilverSummit Healthplan Directory. SilverSummit Healthplan requires that you try at least 2 preferred drugs before you can get a non-preferred drug. Be sure to ask your doctor to write a prescription for a preferred drug first.

What is Prior Authorization?

Some drugs must be approved by SilverSummit Healthplan before you get them. This is called a Prior Authorization (PA). Ask your doctor if your prescription requires this. If it does, ask if there is another medicine that can be used that does not require a PA. SilverSummit Healthplan doctors have been notified in writing of:

- The drugs included in the Preferred Drug List (PDL).
- How to request a prior authorization.
- Special procedures set up for urgent requests. Your doctor can decide if it is necessary to have a non-preferred drug. If so, they must give SilverSummit Healthplan a request for a PA. If SilverSummit Healthplan does not approve the request, we will notify you. We will give you information about the appeal and administrative review process.

DISPENSING LIMITS, QUALITY LIMITS, AND AGE LIMITS

Drugs may be dispensed up to a maximum of a 90 day supply for each new or refill non-controlled substance. A total of 85 percent of the days supplied must have elapsed before the prescription can be refilled. Dispensing outside the quantity limit (QL) or age limits (AL) requires PA. SilverSummit Healthplan may limit how much of a medication you can get at one time. If the physician/clinician feels you have a medical reason for getting a larger amount, he or she can ask for PA. If SilverSummit Healthplan does not grant PA we will notify you and your physician/clinician and provide information regarding the appeal process. Some medications on the SilverSummit Healthplan PDL may have AL. These are set for certain drugs based on Food and Drug Administration (FDA) approved labeling, for safety concerns and quality standards of care. The AL aligns with current FDA alerts for the appropriate use of pharmaceuticals.

STEP THERAPY (ST)

Some medications listed on the SilverSummit Healthplan PDL may require specific medications to be used before you can receive the step therapy medication. If SilverSummit Healthplan has a record that the required medication was tried first, the ST medications are automatically covered. If SilverSummit Healthplan does not have a record that the required medication was tried, you or your physician/clinician may be required to provide additional information. If SilverSummit Healthplan does not grant prior authorization we will notify you and your physician/clinician and provide information regarding the appeal process.

Specialty Services

MENTAL HEALTH AND SUBSTANCE USE

Behavioral health refers to mental health and substance use (alcohol and drug) treatment. Sometimes talking to friends or family members can help you work out a problem. When that is not enough, call your doctor or SilverSummit Healthplan. We can give you support. We can talk to your providers/doctors. We can help you find mental health and substance use specialists to help you.

You do not need a referral from your doctor. You can go to any provider in our network for services. Providers will help you figure out what services might best meet your needs.

SilverSummit Healthplan covers these behavioral health services:

- Outpatient mental health and substance use services (counseling/therapy)
- Psychiatry services and medication management
- Psychiatric inpatient hospital and partial hospital services
- Psychological testing
- Intensive Outpatient Services (IOP)
- Crisis services
- Residential Treatment Center (RTC) Under the age of 21
- Rehabilitative Mental Health (RMH) services, like Program for Assertive Community Treatment (PACT), Basic Skills Training, Peer Support and Psychosocial Rehabilitation (PSR)
- Case management services
- Behavior modification, including Applied Behavioral Analysis
- Other – contact SilverSummit Healthplan for additional covered benefits

How do I know if I/my child needs help?

- Can't cope with daily life
- Feels very sad, stressed or worried
- Not sleeping or eating well
- Thinks about hurting themselves or others

- Bothered by strange thoughts, like hearing or seeing things other people don't
- Drinking alcohol or using other substances
- Having problems at school
- The school or daycare think that your child should see a doctor about mental health or
- substance use problems, including Attention Deficit Hyperactivity Disorder (ADHD)
- Unable to concentrate
- Feels hopeless

If you have a behavioral health concern we can help you find a provider. We want you to have a provider who will be a good match for you. It is important for you to have someone to talk to so you can work on solving problems.

What do I do in a behavioral health emergency?

In a life-threatening emergency, call 911. You can go to a crisis center. You can go to the closest emergency room.

You do not have to wait for an emergency to get help. SilverSummit Healthplan has a crisis support line. The phone number is 1-844-366-2880. They will help you at any time for free. They can help with depression, mental illness, substance use and other behavioral health needs.

RECOVERY AND RESILIENCE

Helping you get and stay healthy is our most important goal. This includes your mind, body, spirit and community. For members who need behavioral healthcare, that means building recovery and resiliency.

- Recovery is a process of making changes that improve your health and quality of life.
- Resiliency is being able to bounce back when there are challenges in your life.

Recovery and resiliency will help you overcome difficulties. This will give you power in your own life. It will help you have feelings of belonging, self-esteem, meaning and hope.

Your behavioral healthcare should focus on recovery and resiliency. It should be:

- **Self-led:** As much as possible, we want you to control your own life, treatment goals and plan of care.
- **Individualized:** Recovery is different for everyone. Your plan of care should fit you. It should be based on your unique strengths, needs, culture and background.
- **Empowered:** You get to be a part of all decisions that affect your life. You should be educated and supported to be actively involved in your care.
- **Holistic:** Your whole life is part of your recovery – mind, body, spirit and community.
- **Flexible:** Recovery is a journey. There may be setbacks and learning experiences. That is okay.
- **Peer Supported:** Research shows that help from people who have had similar challenges is an important part of recovery. Peers can give support, understanding, skills and a sense of community.
- **Respectful:** Everyone involved in your care must respect you. They should help protect you from discrimination and stigma. This includes SilverSummit Healthplan, your providers, friends and family. And maybe most importantly, you should respect yourself.

- **Responsible:** Working toward recovery requires bravery and commitment. You must be responsible for following your plan of care. This includes taking medications and working through the recovery process.
- **Hopeful:** People do overcome the challenges they face. Believing your life will get better is the first step in the recovery process.

THE IMPORTANT ROLE OF FAMILY SUPPORT

Healthy relationships are an important part of recovery. If you struggle with a behavioral health challenge, get help from the people who care about you. Tell them how they can support you.

If your child has a behavioral health condition, you have an important role in helping them. Take an active role in their care. Tell their providers or Member Services about changes you notice. Talk about the care you think they need. Tell your provider or us what you need while you care for your child.

VISION SERVICES

- SilverSummit Healthplan covers vision care services:
- Annual preventive eye exams
- Eyewear (frames and lenses) every year, when requirements are met
- Medically necessary eye care services, including treatment of eye conditions
- Frame repair or replacement of eyeglasses once per year to members of all ages (restrictions may apply)
- Other services as outlined in the Nevada Department of Health and Human Services Medicaid Services Manual: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

Members 21 years of age and older may receive a $100 allowance every year to use toward the purchase and the fitting of medically necessary contact lenses in lieu of standard eyeglasses.

DOULA SERVICES

Pending input.

Pending input.

Pending input.

FAMILY PLANNING SERVICES

SilverSummit Healthplan covers family planning services. The following services should be provided by a Primary Care Provider (PCP), obstetrician or gynecologist:

- Medical history
- Physical exam
- Laboratory tests that are part of the exam (Papanicolaou (Pap) smear; gonorrhea and chlamydia testing, syphilis serology, Human Immunodeficiency Virus (HIV) testing and cervical cancer screening)

- Education about reproductive anatomy and physiology, family planning and Sexually transmitted disease (STD) prevention
- Counseling to help members make informed decisions
- Discussion of results of the exam and treatment options
- Special counseling when needed about pregnancy planning and management, sterilization, genetics and nutrition
- Pregnancy diagnosis, counseling and referral
- Birth Control Devices (such as Norplant)

RELATED EXCLUSIONS

SilverSummit Healthplan does not cover the following:

- Reversal of voluntary sterilization
- Infertility services, including services, supplies or drugs for the diagnosis or treatment of infertility

WELL-CHILD CHECKUPS

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is preventive care for children under the age of 21. These are also called well-child checkups. Doctor visits when your child is well helps make sure they are growing, healthy and safe.

These services are provided at no cost to you. You can call Member Services at 1-844-366-2880 (TTY: 1-844-804-6086, Relay 711) for assistance in scheduling your child's appointment.

This schedule shows when to have well-child visits. You can ask your child's doctor when they should have their next checkup.

Well-child checkups are important for your child's health. Your child can look and feel well but still have a health problem.

During your child's appointment, their PCP appointment will provide a full checkup:

- Health history
- Ears, teeth and eyes
- Diet
- Test records
- Immunization records

Your child's PCP may also provide the following services, if needed:

- Health education
- A referral to a dentist
- A referral for hearing services
- Other services your child may need to stay healthy
- A referral for tobacco cessation

Set up well-child visits when your child is:	
3-5 days old	12 months old
1 month old	15 months old
2 months old	18 months old
4 months old	24 months old
6 months old	30 months old
9 months old	Annually through age 21

Many schools, activities and other organizations require a "sports physical." This is a limited exam. Tell your provider if you need this exam. They can complete the forms you need during your child's well-child checkup.

Immunizations will be given at well-child checkups. Below is the schedule for immunizations:

Age	Immunization
Birth	Hep B
1 month old	Hep B
2 months old	DTaP,Hib,IPV,PCV,Rota
4 months old	DTaP,Hib,IPV,PCV,Rota
6 months old	Hep B, DTaP, Hib, IPV,PCV, Influenza, Rota
12 months old	Hib, PCV, MMR, Varicella, Hep A Series
15 months old	DTaP
4-6 years	DTaP, IPV, MMR, Varicella
11-12 years	Tdap or Td, MCV, HPV (3 doses)
13-18 years	Tdap or Td, MCV, HPV series (catch-up)
Every year	Influenza (after 6 months)

CHILDREN WITH DISABILITIES

SilverSummit Healthplan covers services for individuals under 21 years of age who have disabilities. These disabilities could include sight or hearing issues, Autism, physical disabilities and/or developmental delays. Several helpful services are provided:

- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Behavior Modification
- Peer Support Groups

If your child has special needs we can help you find treatment. Please call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

EXCLUDED SERVICES

Services Not Covered

SilverSummit Healthplan does not pay for these services:

- Experimental and/or investigational procedures, drugs and equipment (Phase I & II Clinical Trials are considered experimental)
- Acupuncture
- Treatment for infertility
- Lasik Surgery/Keratotomy

If there is a counseling or referral service that we do not cover because of moral or religious objections, we will inform you that the service is not covered. We will also inform the Department of Health Care Financing and Policy (DHCFP) on your behalf that we do not cover the service and direct you to how to contact the DHCFP so they may assist you with obtaining the service. This is not a complete list of excluded services. If you want to know if a service is covered, please call Member Services. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

BILLING OR COVERED SERVICES

In cases where a service is denied for seasons that are your responsibility, such as not being eligible on the date of service, or obtaining non-emergent services at a non-network provider without proper authorization, you may be billed for such denials.

Getting Care

MEDICALLY NECESSARY SERVICES

Covered services you receive must be medically necessary. This means we want you to get the care that is most likely to work for you:

- The right care
- The right place
- The right time

SilverSummit Healthplan does not make medical decisions based on financial reasons. We have guidelines to help make sure you get medically necessary care. These are the criteria that we follow for all providers and members. All providers can see the guidelines. Decisions we make about your healthcare will follow those guidelines.

SilverSummit Healthplan does not reward providers or our staff for denying coverage or services.

PROVIDER NETWORK

SilverSummit Healthplan works with a large group of providers. This is called our Provider Network. We do our best to make sure the providers that members need are in our network.

We want providers in our network who give good services. Providers go through a screening process to be in the network. When they are approved, they sign a contract with SilverSummit Healthplan. They agree to meet certain requirements.

There is a list of providers who are in our network. This list is called the Provider Directory. The Provider Directory is on our website. You can call Member Services and ask for a list of providers. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Most of the time providers have to be in our network for us to pay them. If you need to see an out-of- network provider please call Member Services. We will check to see if there is an in-network provider who can treat your medical condition. If not, we will help you find an out-of-network provider. Services from out-of-network providers need prior authorization. See prior authorization section below.

Out-of-network emergency services do not need approval from SilverSummit Healthplan. Call us as soon as you can if you have an emergency and go to an out-of-network provider. We will need to help them so they can get paid.

IMPORTANT: You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

FINDING NEW TREATMENTS TO BETTER CARE FOR YOU

SilverSummit Healthplan has many doctors who are working to make sure you get the best care. They review new treatments for illnesses. They read studies from other doctors and scientific groups. They want to make sure we cover the treatments that are helping people. When new treatments are covered by Nevada Medicaid we tell the SilverSummit Healthplan providers. This lets them give the best and most current treatment to you.

PRIOR AUTHORIZATION FOR SERVICES

You may at some point need services that are not provided by your PCP and require a specialist or specialty care. Some covered services need prior authorization by SilverSummit Healthplan.

This means that the provider has to get the service approved before they treat you. The right treatment is different for every person. Our goal is to make sure you get care to help you be well.

Call your doctor first when you need care. They will help get the authorization. They will tell us why you need that treatment. They will explain how they think it will help you.

A prior authorization decides if a service should be covered. SilverSummit Healthplan will consider the following:

- Medical Necessity – whether the service is needed
- Clinical appropriateness – whether the service is likely to be helpful

Your provider will give us information about why you need the service. Sometimes they talk to us on the phone. Sometimes they send written information. We will check to see if the service is covered. Then we will make sure it is medically necessary.

We will make the decision as quickly as we can based on your medical condition. Usually we decide within 14 calendar days. If the service is urgent we will make the decision within three days. We will let your provider know if the service is approved or denied.

If you or your provider believe we made the wrong decision you can request a second review. This is called an appeal. There is more detailed information about appeals in the “Member Satisfaction” section of this book.

Emergency room (ER) and post stabilization services NEVER need prior authorization. If you have a medical emergency get help right away.

Your provider can tell you if a service needs a prior authorization. You can also call Member Services and ask us. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. If there are big changes to the prior authorization process we will tell you. We will inform our members and providers right away.

PRIOR AUTHORIZATION FOR DRUGS

Some medication needs prior authorization from SilverSummit Healthplan. If you need these drugs, your doctor will ask for authorization. They will give us information about your health. Then SilverSummit Healthplan will decide if we can pay for the drug.

Your doctor must ask for prior authorization in the following situations:

- A drug is listed as non-preferred on the Preferred Drug List
- Certain conditions need to be met prior to you receiving the drug
- The medication is injected in a doctor's office
- The medication is considered a "specialty drug." The list of specialty drugs is on our website.
- You are getting more of the drug than is usually prescribed
- There are other drugs that should be tried first
- You can get up to a 4 day (96 hour) supply of a drug while you are waiting for a decision. The decision will be made within one business day. Your doctor will be notified of the decision.

If you would like more information, you can call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

SECOND MEDICAL OPINION

You have the right to a second opinion by another doctor. You can get this at no cost to you. If you would like a second opinion, tell your provider. You must use a doctor who is in the network. Or you can get prior approval from SilverSummit Healthplan to see a provider out-of-network. SilverSummit Healthplan will pay for a doctor outside of the network if one is not available in-network. Your provider will review the second opinion. They can use that to help decide the best treatment plan.

HOSPITAL

SilverSummit Healthplan covers inpatient hospital services. if you need to be admitted to a hospital and it is not an emergency, your PCP or specialist will arrange for you to go to a hospital in the SilverSummit Healthplan network and will follow your care even if you need other doctors during your hospital stay. SilverSummit Healthplan must approve all services. To find out if a hospital is in the SilverSummit Healthplan network or if you have any other questions on hospital services, please call Member Services 1-844-366-2880 (TDD/TTY 1-844-804-6086) or go the provider directory on the SilverSummit Healthplan website at https//findaprovider.silversummithealthplan.com. If you have any emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital.

GETTING CARE OUT OF STATE

Regular medical care is only covered when you see a SilverSummit Healthplan provider. But, you could be outside of Nevada and need unplanned medical care. In those situations we still want you to get the help you need. We will pay for services in certain situations:

- You are out of state and have a health emergency. Go to a hospital or emergency room where you are. Your follow-up care must be with a SilverSummit Healthplan network provider. Contact your Nevada doctor for a referral if you need to see a specialist.
- You are outside of Nevada and have an urgent health problem. If you need care quickly but it is not an emergency go to an urgent care clinic or you could go to a doctor's office where you are.

Show the provider your SilverSummit Healthplan member ID card and your Nevada Medicaid card. Call us to report your emergency within 48 hours. Providers outside of our network will need help right away so that they can get paid. Providers located outside the state of Nevada have 365 calendar days from the

initial date of service to submit a claim for payment. Only medically necessary emergency and urgent care services will be covered outside of Nevada.

It could be decided that you need special care that is not available in Nevada. If SilverSummit Healthplan approves your special care, the care you get in the other state will be covered.

Members are not covered for services they get outside of the United States.

URGENT CARE AFTER-HOURS

Urgent care is NOT emergency care. You should use urgent care when you have an injury or illness that is not life-threatening but needs to be treated within 48 hours. Use urgent care when you cannot wait for an appointment with your doctor. Only go to the ER if your provider tells you to or if you have a life- threatening emergency.

When you need urgent care, follow these steps:

- Call your PCP. The name and phone number are on your SilverSummit Healthplan member ID card. An after-hours number is listed. Your doctor may help you and give you directions over the phone.
- If you cannot reach your PCP, call our 24/7 Nurse Advice Line. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. You will talk to a nurse. Have your SilverSummit Healthplan member ID card with you. They will ask you for your number. The nurse will help you over the phone. If you need to see a doctor they will help you find care. If you have a mental illness or addiction crisis, do not wait to get help. Call our 24/7 Nurse Advice Line at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.
- SilverSummit Healthplan also has a crisis line that is free to you. That number is 1-844-366-2880. They can help with depression, substance use and other behavioral health needs.
- If your provider tells you to go to the nearest emergency room go right away. Take your SilverSummit Healthplan member ID card and your Nevada Medicaid ID card.

EMERGENCY CARE

Emergency care is always covered by SilverSummit Healthplan in the United States and does not require a prior authorization. An emergency is when not getting medical attention could risk your health. Or the health of your unborn child. An emergency can include an accident, injury or sudden illness.

Go to the emergency room for:

- Broken bone(s)
- Gun or knife wound(s)
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Severe chest pain or heart attack
- Drug overdose
- You feel you are a danger to yourself or others
- Poisoning
- Bad burn(s)
- Shock (you may sweat, feel thirsty or dizzy or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak

Do NOT go to the emergency room for:

- Flu, cold, sore throat or earache
- A sprain or strain
- A cut or scrape that does not need stitches
- To get more medicine or have a prescription refilled
- Diaper rash

Emergency rooms are for emergencies. If you can, call your PCP first. If your condition is severe, call 911 or go to the nearest hospital. You do not need approval.

If you are not sure if it is an emergency, call your doctor. Your doctor will tell you what to do. If your doctor's office is closed there should be a message telling you how to get help.

You can also call our 24/7 Nurse Advice Line. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

You can go to a hospital that is not in the SilverSummit Healthplan network. You can use any hospital emergency room. Show the provider your SilverSummit Healthplan member ID card and your Nevada Medicaid ID card. Providers outside of our network will need help from us right away so that they can get paid. If they do not complete tasks within 30 days you may be responsible for paying for service.

Call your PCP and SilverSummit Healthplan after you go to the emergency room. Call with 48 hours of your emergency. This help us make sure you get the follow-up care you need. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

OUT-OF-NETWORK SERVICES

Out-of-network emergency services do not need approval from SilverSummit Healthplan. All other services from an out-of-network provider need prior authorization. We will check to see if there is an in- network provider who can help you. If not, we will help you find an out-of-network provider.

IMPORTANT: You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services. The phone number is 1-844-366- 2880, TTY: 1-844-804-6086, Relay 711.

POST STABILIZATION SERVICES

Post stabilization services are care you need after an emergency. These help get your health back to normal. These services are important and help make sure you do not have another emergency.

Post stabilization services do not require prior authorization. It does not matter if you get emergency care from an out-of-network provider. Post stabilization services will still be covered.

EMERGENCY TRANSPORTATION

SilverSummit Healthplan covers emergency ambulance transportation. They will take you to the nearest hospital.

Ambulance transportation from one healthcare facility to another is only covered in certain situations:

- Medically necessary
- Arranged for and approved by an in-network provider

If you have an emergency and you need help getting to the emergency room, call 911.

NON-EMERGENCY TRANSPORTATION

If you need a ride to and from your medical appointments for routine visits, call member services at 1-844-366-2880. Press number 2 for transportation. You will be connected to MTM. You can call to

schedule a ride Monday through Friday from 8 a.m. to 5 p.m. Please call us as soon as possible and at least five business days before your scheduled appointment. MTM will work with you to find the right transportation for you and may consult your health care provider.

Non-emergency transportation service is only available to Medicaid recipients. Nevada Check Up members are not eligible for this service.

MEDICALLY NECESSARY SERVICES

Covered services you receive must be medically necessary. This means we want you to get the care that is most likely to work for you:

- The right care
- The right place
- The right time

SilverSummit Healthplan does not make medical decisions based on financial reasons. We have guidelines to help make sure you get medically necessary care. These are the criteria that we follow for all providers and

members. All providers can see the guidelines. Decisions we make about your healthcare will follow those guidelines.

SilverSummit Healthplan does not reward providers or our staff for denying coverage or services.

PROVIDER NETWORK

SilverSummit Healthplan works with a large group of providers. This is called our Provider Network. We do our best to make sure the providers that members need are in our network.

We want providers in our network who give good services. Providers go through a screening process to be in the network. When they are approved, they sign a contract with SilverSummit Healthplan. They agree to meet certain requirements.

There is a list of providers who are in our network. This list is called the Provider Directory. The Provider Directory is on our website. You can call Member Services and ask for a list of providers. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Most of the time providers have to be in our network for us to pay them. If you need to see an out-of- network provider please call Member Services. We will check to see if there is an in-network provider who can treat your medical condition. If not, we will help you find an out-of-network provider. Services from out-of-network providers need prior authorization. See prior authorization section below.

Out-of-network emergency services do not need approval from SilverSummit Healthplan. Call us as soon as you can if you have an emergency and go to an out-of-network provider. We will need to help them so they can get paid.

IMPORTANT: You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

FINDING NEW TREATMENTS TO BETTER CARE FOR YOU

SilverSummit Healthplan has many doctors who are working to make sure you get the best care. They review new treatments for illnesses. They read studies from other doctors and scientific groups. They want to make sure we cover the treatments that are helping people. When new treatments are covered by Nevada Medicaid we tell the SilverSummit Healthplan providers. This lets them give the best and most current treatment to you.

PRIOR AUTHORIZATION FOR SERVICES

You may at some point need services that are not provided by your PCP and require a specialist or specialty care. Some covered services need prior authorization by SilverSummit Healthplan.

This means that the provider has to get the service approved before they treat you. The right treatment is different for every person. Our goal is to make sure you get care to help you be well.

Call your doctor first when you need care. They will help get the authorization. They will tell us why you need that treatment. They will explain how they think it will help you.

A prior authorization decides if a service should be covered. SilverSummit Healthplan will consider the following:

- Medical Necessity – whether the service is needed
- Clinical appropriateness – whether the service is likely to be helpful

Your provider will give us information about why you need the service. Sometimes they talk to us on the phone. Sometimes they send written information. We will check to see if the service is covered. Then we will make sure it is medically necessary.

We will make the decision as quickly as we can based on your medical condition. Usually we decide within 14 calendar days. If the service is urgent we will make the decision within three days. We will let your provider know if the service is approved or denied.

If you or your provider believe we made the wrong decision you can request a second review. This is called an appeal. There is more detailed information about appeals in the "Member Satisfaction" section of this book.

Emergency room (ER) and post stabilization services NEVER need prior authorization. If you have a medical emergency get help right away.

Your provider can tell you if a service needs a prior authorization. You can also call Member Services and ask us. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. If there are big changes to the prior authorization process we will tell you. We will inform our members and providers right away.

PRIOR AUTHORIZATION FOR DRUGS

Some medication needs prior authorization from SilverSummit Healthplan. If you need these drugs, your doctor will ask for authorization. They will give us information about your health. Then SilverSummit Healthplan will decide if we can pay for the drug.

Your doctor must ask for prior authorization in the following situations:

- A drug is listed as non-preferred on the Preferred Drug List
- Certain conditions need to be met prior to you receiving the drug
- The medication is injected in a doctor's office
- The medication is considered a "specialty drug." The list of specialty drugs is on our website.
- You are getting more of the drug than is usually prescribed
- There are other drugs that should be tried first
- You might get up to a three day supply of a drug while you are waiting for a decision. The decision will be made within one business day. Your doctor will be notified of the decision.

If you would like more information, you can call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

SECOND MEDICAL OPINION

You have the right to a second opinion by another doctor. You can get this at no cost to you. If you would like a second opinion, tell your provider. You must use a doctor who is in the network. Or you can get prior approval from SilverSummit Healthplan to see a provider out-of-network. SilverSummit Healthplan will pay for a doctor outside of the network if one is not available in-network. Your provider will review the second opinion. They can use that to help decide the best treatment plan.

GETTING CARE OUT OF STATE

Regular medical care is only covered when you see a SilverSummit Healthplan provider. But, you could be outside of Nevada and need unplanned medical care. In those situations we still want you to get the help you need. We will pay for services in certain situations:

- You are out of state and have a health emergency. Go to a hospital or emergency room where you are. Your follow-up care must be with a SilverSummit Healthplan network provider. Contact your Nevada doctor for a referral if you need to see a specialist.
- You are outside of Nevada and have an urgent health problem. If you need care quickly but it is not an emergency go to an urgent care clinic or you could go to a doctor's office where you are.

Show the provider your SilverSummit Healthplan member ID card and your Nevada Medicaid card. Call us to report your emergency within 48 hours. Providers outside of our network will need help right away so that they can get paid. Providers located outside the state of Nevada have 365 calendar days from the

initial date of service to submit a claim for payment. Only medically necessary emergency and urgent care services will be covered outside of Nevada.

It could be decided that you need special care that is not available in Nevada. If SilverSummit Healthplan approves your special care, the care you get in the other state will be covered.

Members are not covered for services they get outside of the United States.

URGENT CARE AFTER-HOURS

Urgent care is NOT emergency care. You should use urgent care when you have an injury or illness that is not life-threatening but needs to be treated within 48 hours. Use urgent care when you cannot wait for an appointment with your doctor. Only go to the ER if your provider tells you to or if you have a life- threatening emergency.

When you need urgent care, follow these steps:

- Call your PCP. The name and phone number are on your SilverSummit Healthplan member ID card. An after-hours number is listed. Your doctor may help you and give you directions over the phone.
- If you cannot reach your PCP, call our 24/7 Nurse Advice Line. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. You will talk to a nurse. Have your SilverSummit Healthplan member ID card with you. They will ask you for your number. The nurse will help you over the phone. If you need to see a doctor they will help you find care. If you have a mental illness or addiction crisis, do not wait to get help. Call our 24/7 Nurse Advice Line at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

- SilverSummit Healthplan also has a crisis line that is free to you. That number is 1-844-366-2880. They can help with depression, substance use and other behavioral health needs.
- If your provider tells you to go to the nearest emergency room go right away. Take your SilverSummit Healthplan member ID card and your Nevada Medicaid ID card.

EMERGENCY CARE

Emergency care is always covered by SilverSummit Healthplan in the United States and does not require a prior authorization. An emergency is when not getting medical attention could risk your health. Or the health of your unborn child. An emergency can include an accident, injury or sudden illness.

Go to the emergency room for:

- Broken bone(s)
- Gun or knife wound(s)
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Severe chest pain or heart attack
- Drug overdose
- You feel you are a danger to yourself or others
- Poisoning
- Bad burn(s)
- Shock (you may sweat, feel thirsty or dizzy or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak

Do NOT go to the emergency room for:

- Flu, cold, sore throat or earache
- A sprain or strain
- A cut or scrape that does not need stitches
- To get more medicine or have a prescription refilled
- Diaper rash

Emergency rooms are for emergencies. If you can, call your PCP first. If your condition is severe, call 911 or go to the nearest hospital. You do not need approval.

If you are not sure if it is an emergency, call your doctor. Your doctor will tell you what to do. If your doctor's office is closed there should be a message telling you how to get help.

You can also call our 24/7 Nurse Advice Line. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

You can go to a hospital that is not in the SilverSummit Healthplan network. You can use any hospital emergency room. Show the provider your SilverSummit Healthplan member ID card and your Nevada

Medicaid ID card. Providers outside of our network will need help from us right away so that they can get paid. If they do not complete tasks within 30 days you may be responsible for paying for service.

Call your PCP and SilverSummit Healthplan after you go to the emergency room. Call with 48 hours of your emergency. This help us make sure you get the follow-up care you need. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

OUT-OF-NETWORK SERVICES

Out-of-network emergency services do not need approval from SilverSummit Healthplan. All other services from an out-of-network provider need prior authorization. We will check to see if there is an in- network provider who can help you. If not, we will help you find an out-of-network provider.

IMPORTANT: You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services. The phone number is 1-844-366- 2880, TTY: 1-844-804-6086, Relay 711.

POST STABILIZATION SERVICES

Post stabilization services are care you need after an emergency. These help get your health back to normal. These services are important and help make sure you do not have another emergency.

Post stabilization services do not require prior authorization. It does not matter if you get emergency care from an out-of-network provider. Post stabilization services will still be covered.

EMERGENCY TRANSPORTATION

SilverSummit Healthplan covers emergency ambulance transportation. They will take you to the nearest hospital.

Ambulance transportation from one healthcare facility to another is only covered in certain situations:

- Medically necessary
- Arranged for and approved by an in-network provider

If you have an emergency and you need help getting to the emergency room, call 911.

NON-EMERGENCY TRANSPORTATION

If you need a ride to and from your medical appointments for routine visits, call member services at 1-844-366-2880. Press number 2 for transportation. You will be connected to MTM. You can call to schedule a ride Monday through Friday from 8 a.m. to 5 p.m. Please call us as soon as possible and at least five business days before your scheduled appointment. MTM will work with you to find the right transportation for you and may consult your health care provider.

Non-emergency transportation service is only available to Medicaid recipients. Nevada Check Up members are not eligible for this service.

Your Primary Care Provider

MAKING APPOINTMENTS AND GETTING CARE

To get many kinds of care, you can just choose an in-network provider and make an appointment. You do not need approval from SilverSummit Healthplan or a referral from your provider for these services:

- Visits to a PCP, pediatrician or family doctor
- Visits to specialist doctors (some specialists need a referral from you PCP)
- Urgent care
- Obstetric & Gynecology (OB/GYN) care. Make an appointment as soon as you think you are pregnant.
- Behavioral health services (mental health and substance use services)
- Routine vision services

We can help you find or choose a provider. Call Member Services at 1-844-366-2880,

TTY: 1-844-804-6086, Relay 711. We are available Monday through Friday, 8:00 a.m. to 5:00 p.m. PT. Or you can find a provider online at **SilverSummitHealthplan.com**.

These services are always covered even if the provider is not in our network:

- Emergency services
- Family planning services and supplies
- Women’s preventive health service

YOUR PROVIDER DIRECTORY

Your Provider Directory lists all of the in-network providers. SilverSummit Healthplan covers all of these providers. Your Provider Directory includes information on how to contact providers:

- Doctors
- Hospitals
- Specialists
- Urgent care clinics
- Behavioral health providers
- And any other provider we cover

You can use the online Provider Directory (www.providersearch.SilverSummitHealthplan.com) to look for providers. The directory tells you about the type of provider they are. It also tells you where they are located. It tells you what languages they speak and their gender.

If you need a printed List of Providers near you, we can send you one. While a full Provider Directory can also be printed, it's important to know that we are constantly adding providers to our network so a printed version of the full directory may not be most current.

CHOOSING A PRIMARY CARE PROVIDER (PCP)

When you become a SilverSummit Healthplan member, you must choose a Primary Care Provider (PCP). If you do not choose one we will assign you one. We will notify you of your assigned PCP (if you didn't choose one) when you receive your SilverSummit member ID Card. Your PCP will be your main doctor.

They can help coordinate all of your health needs.

You can choose any PCP in our network. You can change your PCP any time.
Your PCP can be any of the following:

- Pediatrician
- Family General Practitioner
- Internist
- Obstetrician/Gynecologist
- Specialist who performs PCP functions for members with disabilities, chronic conditions or complex conditions
- Nurse Practitioner (NA) or Physician's Assistant (PA)

If you would like to know more about a PCP, you can call Member Services. They can tell you what language the provider speaks, if they are in the network, and where they are located. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

If you would like to change your PCP, we will help you.
There are three ways to change your PCP:

1. Look in the forms section of this book. Find the form called "Request to Change My Primary Care Provider Form." Fill this out and send it in.
2. Use the Secure Member Portal. This is on our website, SilverSummitHealthplan.com.
3. Call Member Services to help you. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

After you tell us who your new PCP is, we will send you a new SilverSummit Healthplan member ID card. This will have your new PCP's name and telephone number on it.

VISIT YOUR PCP

After you choose your PCP, make an appointment with them. This will give you both a chance to get to know each other. Your PCP can give you medical care, advice and information about your health.

Call your PCP's office to make an appointment. Remember to bring your SilverSummit Healthplan member ID card and your Nevada Medicaid ID card. If you need help getting an appointment with your PCP, please call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Important: You have unlimited visits to your PCP. There is no cost to you. Make appointments with them when you feel sick. You should also have a wellness checkup every year.

PCP RESPONSIBILITIES

Your PCP has several responsibilities:

- Make sure you get all medically-necessary services when you need them
- Follow-up on the care you get from other medical providers
- Make referrals for specialty care when needed
- Give ongoing care you need
- Keep your medical record up-to-date
- Keep track of all the care you receive
- Give services in the same manner to all of their patients
- Give you regular physical exams, as needed
- Give preventive care visits
- Give you immunizations
- Offer 24/7 contact information
- Discuss what advance directives are and keep them in your medical record
- Treat you with respect
- Advocate for your health
- Offer the same appointment availability to all patients
- Review all of your medications and dosages at every visit

It is helpful to schedule an annual wellness checkup with your PCP. Do this in the first 60 days of choosing them. Schedule a checkup every year. This helps you stay healthy. It helps your PCP find health problems early, when they are easier to treat.

COMMUNICATION WITH YOUR PCP

If you need to change or cancel your appointment let your doctor know as soon as you can. Do not just skip an appointment. A doctor can decide to stop seeing you if you are a "no-show" or are late.

If you cannot be at an appointment, please call at least 24 hours before the appointment. If you need to change an appointment, call the doctor's office as soon as you can. They can make a new appointment for

you. If you need help getting an appointment call Member Services. The phone number is 1-844-366- 2880, TTY: 1-844-804-6086, Relay 711.

Be honest with your doctor so they can help you. If you have questions about your health, your treatment or your medicines, ASK! Your doctor is here to help you.

AFTER-HOURS APPOINTMENTS WITH YOUR PCP

You may need to see another doctor when your PCP's office is closed. Your PCP's office will have suggestions about after-hours care. Call them to get directions. Or, you can call our 24/7 Nurse Advice Line. We can help you at any time. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Some injuries or illnesses are not life-threatening but cannot wait for an office visit. When this happens, you can use an urgent care clinic. If you need help finding an urgent care clinic you can call Member Services or the 24/7 Nurse Advice Line. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Have your SilverSummit Healthplan member ID card with you when you call. They will ask for your number.

If you have an emergency, call 911 or go to the nearest emergency room (ER).

IMPORTANT: Get urgent care from a network provider. Only emergencies, family planning services received from a qualified provider, and newborn care for their first 30 days can be covered if you see an out-of-network provider.

WHAT TO DO IF YOUR PRIMARY CARE PROVIDER (PCP) OR SPECIALIST LEAVES OUR NETWORK

If your primary care ***provider (PCP) or specialist*** decides to leave our provider network we will tell you. We will send you a notice at least 15 days before they leave. If SilverSummit decides to terminate your provider from our network, we will provide you with written notification either by the later of 30 calendar days prior to the effective date of termination, or within 15 business days after receipt or issuance of our notice to your Provider. You may continue to see any in-network doctor or visit any of our in-network urgent care facilities until you select a new PCP. To change your PCP log onto our Secure Member Portal at SilverSummitHealthplan.com. Or call Member Services at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. If you do not change your PCP, we will choose a new one for you. After you have a new PCP, we will send you a new member ID card.

If you are in the middle of getting treatment from your provider, we do not want that treatment interrupted. You can ask to stay with your PCP for at least 30 days after they have left our network. This will give you time to finish that treatment process. Or, it will let you find a new provider who can continue the treatment.

We can only continue coverage if the provider agrees to the following:

- Accept payment at the rates they received as an in-network provider
- Follow the quality standards
- Provide the information we need about your care
- Follow the policies and procedures of SilverSummit Healthplan

If you are seeing a specialist and they leave our network we will help you find a new one. Call Member Services. We will work with you to make sure your care continues.

REFERRALS

You may need to see a specialist. Your PCP can coordinate your care. SilverSummit Healthplan does not need a referral from your PCP to cover the service. The specialist may still need a referral from your PCP. This helps them give you the right treatment. They will tell you if they need a referral.

If you would like help finding an in-network provider, please call Member Services. We will be happy to help.

Some services require a referral from your PCP:

- Diagnostic tests (X-ray & lab)
- Scheduled outpatient hospital services
- Planned inpatient admission
- Renal dialysis (kidney disease)
- Out-of-network providers need SilverSummit Healthplan approval
- Durable Medical Equipment (DME)
- Home healthcare

Access to Care

SilverSummit Healthplan works to make sure our network has all of the providers you need. We have providers all over the state of Nevada. If you cannot find a provider, please let us know. Call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

CONTINUITY AND TRANSITION FOR NEW MEMBERS

Sometimes new members are getting care from a provider who is not in the SilverSummit Healthplan network. Please tell us if you are receiving any ongoing care from a Provider because you have a right to continue that treatment for a period of time:

- New members may keep receiving care from their out-of-network provider for up to 90 days.
- Members who are pregnant may keep the same provider until they have had their baby and completed their first post-partum visit.
- Members who are terminally ill may continue seeing their current Primary Care Provider (PCP) for their care.

If you have questions about continuing to receive care, please call us. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. We will help make sure you continue to receive the care you need. If needed, we can help you find another provider in our network.

APPOINTMENT WAITING TIMES

In-network providers will keep reasonable operation hours. Services will be available to meet your medical needs. You should be given an appointment within these time frames:

TYPE OF APPOINTMENT	SCHEDULING TIME FRAME
PCP Routine, non-urgent or preventive care	Within two weeks, except for chronic medical condition
PCP (monitor chronic medical condition)	According to schedule, which may be less often than every two weeks

Behavioral healthcare, routine, non-urgent	Within 10 business days
PCP (medically necessary)	Same day
Behavioral Health Urgent Care BH Non-Life-threatening Emergency	Within 48 hours Within six hours
Emergency visits	Immediately 24hrs/7 days a week
initial prenatal visits for newly enrolled pregnant women in their first trimester	Within seven calendar days of first request
Initial prenatal visits for newly enrolled pregnant women in the second trimester	Within seven calendar days of first request
Initial prenatal visits for newly enrolled pregnant women in the third trimester	Within three calendar days of first request
High-risk pregnancies	Within three calendar days of identification of high-risk, or immediately if in an emergency
Specialty Care Providers (Specialists) Routine Referral Specialty Care Providers (Specialists) Urgent Referral Specialty Care Providers (Specialist) Emergency Referral	Within 30 days of referral or, sooner if needed Within three calendar days of referral Same day within 24 hours of referral
Lab and X-ray services	Within 21 calendar days or within 48 hours for urgent care.
ER follow-up visits	Follow discharge instructions
In-office waiting time for scheduled appointments	No more than one hour from scheduled appointment – exceptions for emergency, urgent cases, discovery of serious problems, or unanticipated needs
Initial Health Check (EPSDT)	90 calendar days of enrollment

WHAT TO DO IF YOU GET A BILL

SilverSummit Healthplan has a list of services that are covered. These are the services we can pay for when they are medically necessary. This list has been approved by Nevada Medicaid and Nevada Check Up.

Talk with your provider about services that are covered and services that are not covered. When you follow plan rules, you should not be billed for covered services.

WHAT IS COST-SHARING

Cost-sharing is the share of costs covered by your insurance that you pay out of your own pocket. SilverSummit does not collect any costs from you for getting services you need or using your benefits. A Medicaid provider who accepts you as a patient for treatment accepts the responsibility to make certain you receive all medically necessary Medicaid covered services at no cost to you.

Member Services: 1-844-366-2880 • TTY: 1-844-804-6086, Relay 711

Monday – Friday, 8:00 a.m. – 5:00 p.m. PT

Show both your SilverSummit Healthplan member ID card and Nevada Medicaid ID card at every appointment. Ask them if they can see Nevada Medicaid members. Ask them if they are in the SilverSummit Healthplan network. If they say no, call us right way. We may be able to help them get paid. We may be able to add them to our network.

Call your provider right away if you get a bill for a service covered by SilverSummit Healthplan. If you keep getting bills, call Member Services for help. The phone number is 1-844-366-2880,

TTY: 1-844-804-6086, Relay 711. Do not pay the bill yourself. If you pay the bill yourself, we cannot pay you back.

If you ask for a service that is not covered you will have to pay for it yourself. Your provider will ask you to sign a statement saying you will pay for it. If you sign it and get the service, you have to pay the bill.

If you have any questions about a bill, you can call Member Services at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Help For Your Health

EARNING REWARDS PROGRAM DOLLARS

SilverSummit Healthplan rewards members for completing healthy activities. Once you complete a healthy activity and SilverSummit Healthplan is notified, we will mail out your rewards information and program details. You can continue to earn rewards by completing healthy activities that qualify!

How to Earn

You can earn rewards for things like screenings, preventative care, and more. Visit silversummithealthplan.com on how to earn rewards. Log in to check your rewards balance. To see a full listing of healthy activities, please visit silversummithealthplan.com.

Healthy Behavior	
For Kids	Well-child Checkup (age 15 months and younger) Well-child Checkup (ages 2-21)
For Pregnancy	Prenatal Pregnancy Visit* After-Pregnancy Visit Bonus for completing all pregnancy visits!
For Adults	Well-adult Checkup (age 22+) For Men, Annual Prostate Exam (ages 50-69). STI with Chlamydia Screening (women ages 16-24) Cervical Cancer Screening (women ages 21-64) Breast Cancer Screening (women ages 40-74) Comprehensive Diabetes Management (identified diabetics) 90-day PCP visit for new members (must see your PCP within 90 days of becoming a SilverSummit member – can only get this reward or adult well visit reward not both) Preventative Dental Services (must get preventative dental services within 90 days after seeing your PCP if completed at a Federally Qualified Healthcare Center (FQHC)).
For All Members	Flu Shots; Complete health risk screening

*You must be enrolled in our Start Smart for Your Baby® program to receive reward. There is more information about this program later in this book. Visits start counting after you sign up for the program. To sign up, fill out a "Notification of Pregnancy" form at the end of this book. Or you can call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

Note: It may take up to 60 days for your rewards to show up on your card. We will add the bonus after your provider tells us they gave you the service.

PREGNANCY AND MATERNITY SERVICES

There are things you can do to help have a safe pregnancy. Talk to your doctor about medical problems you have, like diabetes and high blood pressure. Do not use tobacco, alcohol or drugs NOW or while you are pregnant.

You should see your doctor before you are pregnant if you have had the following problems:

- Three or more miscarriages
- Premature birth (born before 38 weeks of pregnancy)
- Stillbirth

When you are pregnant, keep the following in mind:

Go to the doctor (OB/GYN) as soon as you think you are pregnant. It is important for you and your baby's health to see a doctor as early as possible.

It you have had problems or a high-risk pregnancy in the past you may need extra care. Choose a doctor you can see the whole time you are pregnant. It is even better to see your doctor before you get pregnant. The doctor can help you get your body ready for pregnancy.

You should choose a pediatrician for your baby before it is born. If you do not choose a pediatrician, SilverSummit Healthplan will choose one for you.

It is important to have healthy lifestyle habits while you are pregnant. This includes exercising, eating balanced meals, not smoking and sleeping 8-10 hours a night. These things can help you and your baby stay healthy.

ABOUT FOLIC ACID

Folic acid is very important for your baby's health. Getting enough folic acid can help prevent serious birth defects. Folic acid is a B vitamin. It is found mostly in leafy green vegetables like kale and spinach. It is also found in enriched grains. Multiple foods contain folic acid in them:

- Orange juice
- Green vegetables
- Beans
- Whole wheat bread
- Peas
- Fortified breakfast cereals
- Enriched rice

It is difficult to get enough folic acid from food alone. Ask your doctor about taking prenatal vitamins. These will have the extra folic acid your baby needs. Your baby needs this right away. This is one reason to see your doctor as soon as you think you could be pregnant.

We have many ways to help you have a healthy pregnancy. To help you, we need to know if you are pregnant. Please call Member Services as soon as you learn you are pregnant. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. We will set up the special care you and your baby need.

START SMART FOR YOUR BABY®

Start Smart for Your Baby (Start Smart) is a program just for pregnant women and mothers with a newborn. It helps make sure you and your baby are healthy during your pregnancy and after you deliver.

When you sign up, we will give you information that can help you. We will talk to you on the phone and send you things in the mail (or via email once the member opts in.). We have a website just for this program. It is startsmartforyourbaby.com.

Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit if you need more help.

SMOKING CESSATION

If you are pregnant and smoke, we can help you stop smoking. We have a free smoking cessation program for pregnant women. The program has trained healthcare workers who are ready to help you one-on-one.

They will provide the education, counseling and support you need to help you quit smoking. Through regular phone calls, you and your health coach develop a plan to make changes to help you stop smoking.

TEXT4BABY

Text4baby is the first health service for pregnant women and babies that uses text messages. Text4baby is a free service.

You can text “BABY” (or “BEBE” for Spanish) to 511411. You will receive 3 free text messages a week. The texts are based on your baby’s due date or birthday. So the information you get will match your baby’s age. The texts will be sent until the baby’s first birthday. Messages include several topics:

- Labor signs and symptoms
- Prenatal care
- Urgent alerts
- Developmental milestones
- Immunizations
- Nutrition
- Birth defect prevention
- Safe sleep
- Safety
- And more

Text “STOP” (to 511411) to stop getting text messages. You can also text “HELP” (to 511411) for questions at any time. For more information, visit www.text4baby.org.

SEVEN DAY FOLLOW-UP INCENTIVE

If you or your child have been in the hospital for a behavioral health concern, it is important for you to see your provider after you go home. This appointment should be within 7 days after your discharge from the hospital. Follow-up appointments help people recover from the crisis that led to them going to the hospital.

Make this appointment with one of the following:

- Psychiatrist
- Counselor
- Other licensed behavioral health clinician

When you attend your follow-up appointment in seven or less days you will receive a gift from SilverSummit Healthplan. Adults will receive a gift card. Children will receive a HOPE Bear.

If you have any difficulty scheduling a follow-up appointment we will help you. If you have a Care Manager you can call them. Or you can call Member Services. The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

CARE MANAGEMENT

Some members have special needs. SilverSummit Healthplan offers one-on-one help for members with a specific health concern. - You or your doctor can refer for care management services. A care manager can also help connect you with other state and local programs. Your care manager will also help you when you are leaving the hospital or other short-term medical setting to make sure you get the services you need when you get home. These services may include home care visits or therapies.

Care Management gives support to members who need extra help to be as healthy as possible. Services include the following:

- Education about lifestyle changes
- Home care
- Community resources

SHOULD YOU BE IN CARE MANAGEMENT?

- Care Management could be helpful to you in many situations:
- Have a life long illness like asthma or diabetes
- Are at risk for a serious condition like Sickle Cell Anemia or HIV/AIDS
- Have a behavioral health need
- Have a child with special needs
- Have a developmental or physical disability
- Have some other special healthcare need

WHAT IS A CARE MANAGER?

A Care Manager is a personal wellness coach. They work closely with you to plan your health goals. They help you figure out the steps to achieve your goals.

Our Care Management teams include several professionals:

- Registered Nurses (RN)
- Licensed Social Workers (LSW)
- Behavioral Health Clinicians (counselor or social worker)
- MemberConnections Representatives

Your Care Manager will work with you and your providers to help you get the care you need. Together, you will develop your individualized plan of care. Sometimes they can arrange treatment that is not typical for most people. They may work with our Medical Director to authorize additional care in the following situations:

- A member has a severe condition and treatment will probably take a long time
- There are alternative services that can be used instead of covered services that are more expensive
- More services than usual are necessary

SilverSummit Healthplan has the right to stop an alternative care plan. We can stop the plan if it is no longer appropriate or it doesn't work. You would get a letter and be told at least 10 days before a care plan is stopped.

For more information about Care Management you can call us.

The number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. You can ask to speak with Care Management. We will help you find the right resources for your needs.

CHRONIC CARE MANAGEMENT

SilverSummit Healthplan offers chronic care management services. This is to help our members with long lasting conditions improve their quality of life. Our Health Coaches help doctors, specialists and the member work together for the best care. They teach the member about their condition. They help the member make a plan to improve their health.

Members with these conditions may benefit from chronic care management:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Anxiety
- Asthma
- Bipolar Disorder
- Congestive Heart Failure
- Diabetes
- Depression
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Hypertension
- Obesity/Weight Management
- Pain Management
- Perinatal Substance Use
- Schizophrenia
- Sickle Cell Disease

OUR HEALTH COACHES WILL LISTEN TO YOUR CONCERNS. THEY WILL HELP YOU GET THE THINGS YOU NEED. THEY WILL TALK TO YOU ABOUT SEVERAL THINGS:

- Understanding your condition
- Making a plan of care
- How to take your medicine
- What screening tests to get
- When to call your doctor or other provider

The goal of chronic care management is to help you understand and take control of your health. Better control means better health.

For more information, call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

General Eligibility

GENERAL ELIGIBILITY

SilverSummit Healthplan is a health plan available through the Nevada Department of Health and Human Services' Nevada Medicaid and Nevada Check Up program. SilverSummit Healthplan does not decide who can get the plan. The Division of Welfare and Supportive Services (DWSS) decides your Medicaid eligibility. Several people may be eligible:

- Parents/caretaker relatives of children under age 19
- Pregnant women
- Qualified children under age 19
- Poverty-level children under age 19
- Special group of Medicaid (Children's Health Insurance Program (CHIP) (M-CHIP) children, ages 6 through 18; eligible for CHIP matching rate
- Former foster care adults (individuals up to age 26 who aged out of the Nevada foster care program)
- Newborns of Medicaid-eligible mothers
- Individuals receiving Transitional/Extended Medical Assistance
- Aged, blind and disabled (regardless of age)

You can get more information about who can be involved. Call the DWSS, they can tell you more.

MAJOR LIFE CHANGES

Major life changes can affect your eligibility with Nevada Check Up and Medicaid. It is very important to let Nevada Check Up, Medicaid and SilverSummit Healthplan know when you have these life changes. You may lose your coverage if Nevada Check Up and Medicaid cannot contact you.

If you have a major life change, please call Nevada Check Up and Medicaid. The phone number for Nevada Check Up is 1-877-543-7669. The phone numbers for NV Medicaid are Las Vegas District Office: (702) 668-4200 and Reno District Office: (775) 687-1900. You can visit one of their local offices or go to their website.

The websites for Nevada Check Up are www.nevadahealthlink.com or https://dwss.nv.gov/Medical/

NCUMAIN/. The website for Nevada Medicaid is accessnevada.dwss.nv.gov. Contact them as soon you have big a change in your life.

Major life changes include several situations:

- Changing your name
- A change in your health insurance.
- If you add or lose other insurance coverage. If you are added to or removed from someone else's insurance.
- Moving to a new address
- Changing jobs
- Your ability or disability changes
- Your family changes. This might mean your family got bigger because of a birth or a marriage. Or your family got smaller. This may be because a family member dies or moves away.
- Changes in your income or assets
- You become pregnant
- Call us if you are pregnant. We have special help for you and your baby. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

OTHER INSURANCE

If you have other health insurance please tell us. Call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

This will help us make sure all of your medical services get paid for. We will tell Nevada DHHS about your other insurance.

WORKER'S COMPENSATION AND OTHER CLAIMS

If you are hurt at work, Workers Compensation may cover your injuries. SilverSummit Healthplan will not pay for services covered by Workers' Compensation.

It may take a little while to review work related injuries. SilverSummit Healthplan will provide the healthcare services you need while those questions are getting answered. Before we can do this, you have to agree to give us information we need. We will need documents to have Workers' Compensation cover those services.

Contact SilverSummit in the following instances:

- You are involved in a personal injury lawsuit
- You are involved in a medical malpractice lawsuit
- You have an auto accident claim

Call Member Services to tell us. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. There may be insurance coverage through other companies that will help pay for your medical services.

OPEN ENROLLMENT

Open enrollment is when you can decide to stay with SilverSummit Healthplan or choose a different health plan. Nevada Medicaid and Check Up have four plans you can choose from. Open enrollment only happens once a year.

To switch plans, complete and return the form mailed to you. If you lost the form or did not receive one, you can request to switch by sending in a signed written letter to the following address: Nevada Medicaid Attn. MCO Changes P.O. Box 30042, Reno, NV 89520. You can also call the Medicaid District Office with questions at: Las Vegas Office: 702-668-4200; Reno Office: 775-687-1900. The Medicaid District Office will provide you with plan options and educational materials so you can make an informed choice.

During open enrollment, you have the right to choose any plan. If you do not choose a new health plan, you will stay with SilverSummit Healthplan.

NEWBORN ENROLLMENT

If you are a SilverSummit Healthplan member when your baby is born, your baby is also covered by our plan. Sometimes there is a waiting period to get your newborn's Nevada Check Up ID activated. During this time, medically necessary services are still covered. SilverSummit Healthplan will cover services that are appropriately authorized.

DISENROLLMENT

HOW TO DISENROLL FROM SILVERSUMMIT HEALTHPLAN

We want you to be happy with SilverSummit. If there is something we can help you with, please call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. We'll work with you to try to fix the problem. If you're still not happy, you may:

Change to another health plan at any time during the first 90 days of enrolling with SilverSummit.

If you're a new Medicaid or Nevada Check Up member, you may mail your request to: Nevada Medicaid

Attn: MCO ChangesP.O. Box 30042 Reno, NV 89520

Please include your Medicaid number, your address and your phone number.

Change health plans without cause during the annual open enrollment period.

If you pick SilverSummit or a Medicaid plan during open enrollment, you will be enrolled in the plan for the next 12 months. You can choose to switch your plan within the first 90 days after open enrollment. On the 91st day, you can only change plans during the next 12 months if you can show good cause.

Change health plans after the first 90 days of enrollment with good cause.

Good cause reasons to disenroll are:

- You move out of Nevada
- The contract between SilverSummit Healthplan and the State of Nevada ends

- SilverSummit Healthplan does not, because of moral or religious objections, cover the service you wantYou need two or more services at the same time and SilverSummit Healthplan does not have those services available. Your PCP and another provider decide that getting those services separately would cause you risk.
- Other reasons, including but not limited to:
    - Poor quality of care
    - Lack of access to services that are covered by the plan
    - Lack of access to providers who have experience with your healthcare needs Wanting to go to a provider that isn't in the SilverSummit network isn't considered "good cause."

HOW TO DISENROLL

If you want to leave SilverSummit to enroll in a different health plan, you can:

- Call SilverSummit member services toll-free at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. Ask for a disenrollment form that you can complete. You can also complete the form by phone with a member services employee.
- Send us a letter and include:
    - Your name
    - SilverSummit ID number
    - A phone number where you can be reached
    - Why you want to disenroll. Include a good cause reason listed above.

Send the completed form or letter to:

SilverSummit Healthplan
Attn: Customer Service
2500 N. Buffalo Drive Suite 250
Las Vegas, NV 89128

When we get your form or letter, we'll review it and make a decision. We'll send you a letter within 14 days to tell you what we decide. If your medical needs require a faster response, we'll make our decision as quickly as possible.

If you disagree with our decision, you can file an appeal. This is how you ask us to change our decision.

You or someone that you name to act for you, can ask us to change our decision. This is called an appeal. You can ask for an appeal in writing or by calling us. If you want to appeal, you must tell us within sixty (60) days of the date of our notification of decision letter. You can file an appeal by phone, fax, or writing to us at:

SilverSummit Healthplan Appeals Department
2500 North Buffalo Drive, Suite 250 Las Vegas, NV 89128
Phone 1-844-366-2880
TDD/TTY 1-844-804-6086
Fax 1-855-742-0125

If you appeal by phone, you must also send in a written, signed appeal.

- The written appeal should include the following information:
- Your name
- Your member number
- A phone number where we can reach you
- Why you think we should change the decision

You or your designated representative can ask for an appeal. We will give you an answer within thirty (30) calendar days of you asking for an appeal. If you or your designated representative believe that waiting up to 30 calendar days to decide your appeal could seriously risk your life or health, including your being able to reach, keep, or get back to your maximum function, you or your designated representative should tell us this when asking for an appeal. If we agree, we will make a decision sooner (within 72 hours of receiving the request) on your appeal. This is called an "expedited appeal." An expedited appeal may be filed orally. It does not have to be filed in writing.

You must give written permission for someone else to file an appeal for you. No one can speak for you without your permission. There is a "Personal Appeal Representative Form" at the back of this book that will tell us that you give someone this permission to appeal for you.

If you need help filing your appeal call Member Services.

If you do not agree with the appeal decision, you will then have the right to a State Fair Hearing.

INVOLUNTARY DISENROLLMENT FOR CAUSE

SilverSummit Healthplan may ask for a member to be disenrolled. We would notify the Enrollment Broker in writing. SilverSummit Healthplan may ask for disenrollment at any time in the following situations:

- The member allows someone else to use their SilverSummit Healthplan ID card
- The member's use of services is fraudulent or abusive
- The member's behavior is so disruptive, threatening or uncooperative that behavior makes us unable to cover or provide services. This does not include behavior that is because of special needs, or physical or behavioral health problems.
- The member moves out of Nevada

SilverSummit Healthplan may not ask for disenrollment in the following situations:

- The member has a pre-existing medical condition
- The member has a change in health status
- The member uses medical services
- The member has diminished mental capacity
- The member refuses medical care or diagnostic testing

- The member completes a grievance or appeal
- The member asks to change providers
- The member’s race, color, national origin, age, disability, sex, health status or the need for healthcare services.

REASSIGNMENT

If you have been disenrolled due to loss of eligibility for Nevada Check Up or Medicaid, and you become eligible again, you will be reassigned to an MCO based on the following criteria:

- By family affiliation (you have other family members who are enrolled with an MCO)
- By history (you’re assigned to an MCO that you were enrolled with in the past)
- Randomly

Member Satisfaction

MEMBER SATISFACTION

We hope our members are always happy with our services. We hope our members are always happy with our providers. If you are not happy, we want to know! SilverSummit Healthplan has steps for handling problems you may have. Your voice is important to us.

SilverSummit Healthplan gives members ways to tell us how we are doing:

- Members Advisory Committee
- Customer Service Representatives Member satisfaction surveys
- Grievance System process

MEMBER ADVISORY COMMITTEE

You can help SilverSummit Healthplan improve the way our health plan works. Through our Members Advisory Committee, we give members like you the chance to share your thoughts and ideas with us. The committee shares health education with our members. It discusses ways to focus on preventative health. The Members Advisory Committee meets 4 times a year in different parts of the state. There are opportunities to attend without traveling.

At these meetings, you can talk about the services you get. You can tell us how we are doing. You can share your ideas on policy changes. You may ask questions or share any concerns.

Would you like to join? Just call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. They can give you information about joining the Members Advisory Committee.

CULTURAL COMPETENCY

It is important to SilverSummit Healthplan that we give services that are culturally competent. It is important to us that our providers are also culturally competent. This means that you receive services that are respectful of your social and cultural needs.

We check the cultural competency level of our providers. We give them training and tools to help them.

Network providers are required to understand and ensure the following:

- Members know that they can get help with interpretation. This includes many languages, signers and TDD/TTY services. There is no cost for these services.
- Race and ethnicity have an influence on health and treatment decisions. Providers should understand these issues.
- SilverSummit Healthplan staff who help members are given cultural competency training.
- We will collect data to help us make good decisions. We will try our best to collect race and language specific information from members. We will also explain race/ethnicity categories to a member. This will help members identify the race/ethnicity for themselves and their children.

CULTURAL COMPETENCY CONTINUED

- Person centered care-planning thinks about all of the parts of a person:
- Race
- Country of origin
- Native language
- Social class
- Religion
- Mental or physical abilities
- Other characteristics that may influence the member's perspective on healthcare
- Heritage
- Acculturation
- Age
- Gender
- Sexual orientation

Office sites have posted and printed materials in several languages.

QUALITY IMPROVEMENT PROGRAM

SilverSummit Healthplan is committed to making sure you get quality healthcare for you and your family. Our goal is to improve your health. We want to help you with any illness or disability.

Our programs follow standards of the National Committee on Quality Assurance (NCQA) quality standards.

To help members get safe, reliable, quality healthcare, our programs include:

- Review of doctors and providers when they become part of our network
- Making sure members have access to all types of healthcare services
- Giving members support and education about general healthcare and specific diseases
- Sending members reminders to get annual tests like adult physicals, cervical cancer screenings or breast cancer screenings
- Looking into any member concerns regarding care received

- SilverSummit Healthplan believes your ideas can help make services better. We send out a member survey each year. The survey asks you questions about your experience with the healthcare and services you are receiving. We hope you will take the time to send us your answers.

If you have questions about our Quality Improvement Program, how SilverSummit operates, our structure or need information about our Provider incentive plans, please contact Member Services.

ADVANCE DIRECTIVES

Advance Directives protect your rights for medical care. All SilverSummit Healthplan adult members have a right to make Advance Directives for their healthcare decisions. This includes planning treatment before you need it.

An Advance Directive tells people what you want if you cannot make your own decisions. If you have a medical emergency and cannot communicate what you need, your doctors will already know. An Advance Directive will not take away your right to make your own decisions.

To make an Advance Directive, complete the "Advance Directives form" on our website. Member Services can help you find the form. The phone number is1-844-366-2880, TTY: 1-844-804-6086, Relay 711. When you fill out the form, ask your doctor and/or provider to put it in your file.

Together with your doctor and/or other provider, you can make decisions before you have a crisis or emergency. This will help providers understand your wishes about your health. You can relax because they already know your preferences.

Examples of Common Types of Advance Directives Include:

A Living Will: tells doctors what kind of medical care you want to receive (or not receive) if you are no longer able to communicate what you want. This lets you decide ahead of time which life-prolonging treatments you would want or not want. This could include several different things:

- Feeding tubes
- Breathing machines
- Organ transplants
- Treatments to make you comfortable

A living will is only used when you are near the end of life, and there is no hope for you to recover.

A Healthcare Power of Attorney: Names someone who is allowed to make healthcare decisions for you if you are no longer able to communicate what you want.

A "Do Not Resuscitate" (DNR) Order: Tells healthcare providers not to give Cardiopulmonary Resuscitation (CPR) if your heart and/or breathing stop. A DNR order is only about CPR. It does not provide instructions about other treatments.

You should not be discriminated against for not having an Advance Directive.

SilverSummit Healthplan will tell you about any changes to state law affecting Advance Directives. We will send you this information as soon as possible. We will send it within 90 days after the date of change. Ask your

provider or call SilverSummit Healthplan to find out more about Advance Directives.

Please contact the Nevada Division of Healthcare Financing and Policy ("DHCFP") to file a complaint if your Advance Directive was not followed. You can visit their website at dhcfp.nv.gov.

GRIEVANCES

Grievances are spoken or written complaints given to SilverSummit Healthplan by you or your authorized representative. These complaints can be about any action of SilverSummit Healthplan or a provider in our network:

- Quality of care
- Personal behavior like rudeness of a provider or employee
- Failure to respect a member's rights
- Harmful administrative processes or operations

SilverSummit Healthplan wants to resolve your concerns. We will not hold it against you if you file a grievance. We will not treat you differently.

HOW TO FILE A GRIEVANCE

You can file a grievance in any way that works best for you:

- Call Member Services. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.
- Use the member portal on our website: **SilverSummitHealthplan.com**
- Give it to us in person or by mail:

SilverSummit Healthplan ATTN: Grievances

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

Send a fax. The fax number is 1-855-742-0125

Be sure to include the necessary personal information:

- Your first and last name
- Your Nevada Medicaid ID number
- Your address and telephone number
- What you are unhappy with
- What you would like to have happen

There is a form at the end of this book for filing a grievance. You do not have to use it. It may help you know what information we need.

If you file a written grievance, we will send you a letter so you know we received it. We will send the letter within 10 business days.

SilverSummit Healthplan will keep a copy of your grievance for 10 years. We will also keep copies of responses we send you.

If someone else is going to file a grievance for you, we must have your written permission for that person to file your grievance. No one can act on your behalf without your permission.

To give them permission there is a "Personal Appeal Representation Form." It is in the forms section of this book and on our website. You can also call Member Services. This form can be used to give the right to file your grievance or appeal to someone else.

You may have proof or information supporting your grievance. If you do, please send it to us so we can add it to your information. You can ask to get copies of any documentation SilverSummit Healthplan used to make the decision about your grievance.

We will resolve your grievance as quickly as your situation needs us to. If you believe the situation is urgent please tell us. You will get a letter from us within 90 calendar days. That will tell you how we settled the concern.

We will not hold it against you if you file a grievance. We will not treat you differently in any way. We want to know your concerns so we can improve our services.

APPEALS

An appeal is when you ask us to review a decision we made about authorization. You might want to file an appeal when a service has been denied, limited, reduced or ended. Appeals may be filed by a member (parent or guardian of a minor member). An appeal tells us to look at a denial again to make sure it was the right decision.

Appeal a decision in the following situations:

- Denies the care you asked for
- Authorizes a smaller amount of care
- Ends care that was approved previously
- Denies payment for care you may have to pay for

These types of decisions are called an "adverse benefit determination." If any of these actions occur, we will send you a letter. The letter will explain what we decided and why we made that decision. It will also have information about your appeal rights.

There will be a date on your adverse benefit determination letter. If you want to file an appeal, you have to do it within 60 calendar days of that date.

You can request copies of any documentation SilverSummit Healthplan used to make the decision about your care or appeal. You can also request a copy of your member records. SilverSummit Healthplan keeps records for 10 years.

We will not hold it against you if you file an appeal. We will not treat you differently in any way.

HOW TO FILE AN APPEAL

To file an appeal you can call Member Services, fill out the appeal form in the back of this book, send us a letter or electronically fax the letter or form. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711 Send your letter to SilverSummit Healthplan.

Appeals for physical health and pharmacy services should be sent to:

SilverSummit Healthplan
ATTN: Appeals
2500 North Buffalo Drive, Suite 250 Las Vegas, NV 89128
You can fax the appeal to 1-855-742-0125.

Appeals for mental health or substance use services should be sent to:

SilverSummit Healthplan
ATTN: Appeals
12515-8 Research Blvd., Suite 400
Austin, TX 78759
You can fax the appeal to 1-866-714-7991.

There is a form at the end of this book for filing an appeal. You do not have to use it. But it may help you know what information we need.

After we receive your call, written or electronic appeal, we will send you a letter. This will tell you that we received it.

After we make a decision, we will send you another letter. You will have that decision within 30 days. If there is a reason we cannot decide within 30 days we may ask for an extension from Nevada Medicaid or Nevada Check Up. We would have to tell them why we want the extension. We would have to show why the extension is in your best interest.

You can also request an extension if more time is needed. The extension would be 14 additional days. If you want an extension call Member Services. Ask for the appeals department. The phone number is 1-844-366-2880, TTY: 1-844-804-6086, Relay 711.

WHO MAY FILE AN APPEAL?

- You, the adult member
- The parent or guardian of a minor member
- A person named by you (your representative)
- A provider acting for you (Provider is your representative)

You must give written permission for someone else to file an appeal for you. No one can speak for you without your permission. There is a "Personal Appeal Representative Form" at the back of this book that will tell us that you give someone this permission to appeal for you. You will get a copy of this form with your adverse benefit determination letters. It is also on our website: **SilverSummitHealthplan.com**.

The Personal Appeal Representative Form must be sent in with your appeal. We have to receive it within 60 days of your adverse benefit determination letter.

If you need help filing your appeal call Member Services. The phone number is at 1-844-366-2880, TTY: 1-844-804-6086, Relay 711. We have people to help you Monday through Friday, 8:00 a.m. to 5:00 p.m. PT.

CONTINUING TO RECEIVE SERVICES

You can ask to keep receiving care while we review your appeal. You must ask within 10 days after receiving your adverse benefit determination letter.

IMPORTANT: If the appeal finds our decision was right, you may have to pay for the service.

FAST APPEAL DECISIONS

If your medical condition is urgent, we can make a decision about your appeal much faster. You may need a fast decision if not getting the treatment will have adverse effects:

- Risk of serious health problems or death
- Serious problems with your heart, lungs or other body parts
- You going into a hospital

Your doctor must agree that you have an urgent need.

If you think you need a fast appeal decision call Member Services. The phone number is 1-844-366- 2880, TTY: 1-844-804-6086, Relay 711. Ask for the appeals department. Our Medical Director will make a decision, and we will let you know within 72 hours.

STATE FAIR HEARINGS

You may disagree with an appeal decision. If that happens you may request a State Fair Hearing. This is an appeal that goes to Nevada DHCFP instead of SilverSummit Healthplan. In a State Fair Hearing, Nevada DHCFP will make the final decision.

You must complete the SilverSummit Healthplan appeals process before you can request a State Fair Hearing. After we have finished your appeal, we will send you a letter. You have 120 days from the date on the letter to ask for a State Fair Hearing.

You can ask to keep receiving care during the State Fair Hearing process. You must ask within 10 days from the date on your letter.

IMPORTANT: If the State Fair Hearing finds our decision was right, you may have to pay for the service. Requests for a State Fair Hearing can be submitted in writing or electronically. Mail your request to:

Nevada Department of Administration, Hearings Office
1100 East William Street Suite 101
Carson City, NV 89701
Phone: 775-684-3676 • Toll Free: 1-800-992-0900

You can also submit an electronic request by accessing the Recipient Fair Hearings Request form at http://dhcfp.nv.gov/Resources/PI/Hearings/.

For more information about the State Fair Hearing process, contact Nevada DHCFP.

REPORTING ALLEGED MARKETING VIOLATIONS

Nevada DHCFP has rules for marketing to potential members. SilverSummit Healthplan follows these rules. If you notice activities by any health plan that could be against Nevada DHCFP rules they want you to tell them. Fill out the "Nevada DHCFP Marketing Complaint Form". It is the "Forms" section at the end of this book. They will investigate.

Specific activities are not allowed:

- Activities to get you to change your plan. You will get information from your health plan (SilverSummit Healthplan) but should not from others. This means mail, email, phone calls or visits to your home.
- Attaching a Nevada Check Up and Medicaid application to marketing materials
- Showing or giving out marketing materials in a hospital emergency room
- Giving out information that is false, confusing, misleading or meant to trick members
- Helping someone choose a health plan
- Comparing themselves to other health plans by name
- Charging members for items or services at events
- Charging members money to use their website
- Trying to sell members other insurance plans

REPORTING FRAUD, WASTE, AND ABUSE

SilverSummit Healthplan is serious about finding and reporting when Nevada Check Up and Medicaid funds are used in the wrong way. This is called fraud, waste, and abuse.

Fraud means a member, provider or other person is misusing Nevada Check Up and Medicaid program resources:

- Giving someone your member ID card so they can get services under your name
- Using another person's member ID card to get services under their name
- A provider billing for the same service twice
- A provider billing for a service that never happened

Your healthcare benefits are given to you because you met the rules of the program. They are not for anyone else. You must not share your benefits with anyone. If you misuse your benefits, you could lose them. Nevada Department of Health and Human Services (DHHS) could also take legal action against you if you misuse your benefits.

If you think a provider, member or other person is misusing Nevada Medicaid or Nevada Check Up benefits, please tell us right away. SilverSummit Healthplan will take your call seriously. You do not need to give your name when you call Member Services. The phone number is 1-844-366-2880, TTY: 1-844- 804-6086, Relay 711. You can also call our Fraud, Waste and Abuse helpline at 1-866-685-8664, contact us through SilverSummitHealthplan.com, email us at ReportFWA@SilverSummithealthplan.com or via US Mail at the following address:

SilverSummit Healthplan
Attn: Compliance Department
2500 N. Buffalo Drive, Suite 250
Las Vegas, NV 89128

MEMBER RIGHTS

As a member you have certain rights. SilverSummit Healthplan wants to always respect your rights. We expect our providers to respect your rights.

Your rights are important to us:

- To be treated with respect, dignity and privacy
- To receive information about SilverSummit Healthplan, its services, its practitioners and providers and member rights and responsibilities.
- To pick or change doctors from the provider network
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To be able to get in touch with your provider
- To go to any provider or clinic for family planning services
- To get care right away if you have a medical emergency
- To be told what your illness or medical condition is
- To be told your treatment options and what your provider thinks is best
- To work with your doctor to make decisions about your healthcare
- To give permission before the start of diagnosis, treatment or surgery
- To refuse treatment
- To have your personal information in medical records kept private
- To request a copy of your medical record
- To request your medical record be amended or corrected as allowed by law
- To report any complaint, grievance or appeal about your provider or medical care
- To appeal action that reduces or denies services based on medical criteria
- To work with your providers and not be pressured into making decisions about treatment
- To not be discriminated against due to race, color, national origin, age, disability, sex, health status or the need for healthcare services
- To request a second opinion

- To be notified at the time of enrollment and then also annually of your disenrollment rights
- To make an Advance Directive
- To file any complaint with Nevada DHCFP if your Advance Directive is not followed
- To choose a provider who gives you care whenever possible and appropriate
- To receive accessible healthcare services similar to services given under Medicaid FFS which would include similar amount, duration and scope.
- To get enough services to be reasonably expected to achieve the goal of the treatment
- To not have your services denied or reduced just because of a specific diagnosis, type of illness or medical condition
- To use your rights without any negative effects from Nevada DHHS, SilverSummit Healthplan, its providers or contractors
- To receive all written member information from SilverSummit Healthplan:
- At no cost to you
- In languages other than English
- In other ways, to help with the special needs of members who may have trouble reading the information for any reason
- To get interpretation services for free in any language
- To be told that interpretation services are available and how to get them
- To get help understanding the requirements and benefits of SilverSummit Healthplan from Nevada DHHS and its Enrollment Broker
- To receive a copy of Member rights and responsibilities and the right to make recommendations about Silver Summit Healthplan's rights and responsibilities statement.

MEMBER RESPONSIBILITIES

As a member you have certain responsibilities. Treatment can work better if you do these things:

Notify Nevada Medicaid or Nevada Check Up if the following happens:

- Your family size changes
- To provide SilverSummit Healthplan and your providers with correct and complete medical information they need in order to provide care.
- You move out of the state or have other address changes
- You get or have health coverage under another policy, other third party or there are changes to that coverage
- Work on improving your own health
- Tell SilverSummit Healthplan when you go to the emergency room
- Talk to your provider about preauthorization of services they recommend
- Be aware of cost-sharing responsibilities and make payments that you are responsible for.
- Inform SilverSummit Healthplan if your member ID card is lost or stolen
- Show your member ID card and Nevada Medicaid ID card when getting healthcare services
- Know SilverSummit Healthplan procedures, coverage rules and restrictions the best that you can

- Contact SilverSummit Healthplan when you need information or have questions
- Give providers accurate and complete medical information
- Follow prescribed treatment. Or tell your provider the reason(s) treatment cannot be followed as soon as possible.
- Ask your provider questions to help you understand treatment. Learn about the possible risks, benefits and costs of treatment alternatives. Make care decisions after you have thought about all of these things.
- Be actively involved in your treatment. Understand your health problems and be a part of making treatment goals with your provider as much as you can.
- Follow the grievance process if you have concerns about your care

Notice of Privacy Practices

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective 07.01.2017

For help to translate or understand this, please call 1-844-366-2880.
Hearing impaired TTY/TDD 1-844-804-6086, Relay 771.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-844-366-2880. (TTY/TDD 1-844-804-6086).

Interpreter services are provided free of charge to you.

Covered Entity's Duties

SilverSummit Healthplan is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). SilverSummit Healthplan is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. We protect all of your oral, written and electronic PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

SilverSummit Healthplan reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. SilverSummit Healthplan will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties or other privacy practices stated in the notice. We will make any revised notices available on our website and in any material we send.

PERMISSIBLE USES AND DISCLOSURES OF YOUR PHI

The following is a list of how we may use or disclose your PHI without your permission or authorization:

Treatment—We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you, to coordinate your treatment among providers or to assist us in making prior authorization decisions related to your benefits.

Payment—We may use and disclose your PHI to make benefit payments for the healthcare services provided to you. We may disclose your PHI to another health plan, to a healthcare provider or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity and performing utilization review of claims.

Healthcare Operations—We may use and disclose your PHI in the performance of our healthcare operations. These activities may include providing customer services, responding to complaints and appeals, providing case management and care coordination, conducting medical review of claims and other quality assessment and improvement activities. We may also in our healthcare operations disclose PHI to business associates with whom we have written agreements containing terms to protect the privacy of your PHI.

We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its healthcare operations relating to quality assessment and improvement

activities, reviewing the competence or qualifications of healthcare professionals, case management and care coordination or detecting or preventing healthcare fraud and abuse.

Group Health Plan/Plan Sponsor Disclosures—We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a healthcare program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI

Fundraising Activities—We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt out (stop), receiving such communications in the future.

Underwriting Purposes—We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Appointment Reminders/Treatment Alternatives—We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

As Required by Law—If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

Public Health Activities—We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.

Victims of Abuse and Neglect—We may disclose your PHI to a local, state or federal government authority (including social services or a protective services agency authorized by law) to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

Judicial and Administrative Proceedings—We may disclose your PHI in judicial and administrative proceedings as well as in response to an order of a court, administrative tribunal or in response to a subpoena, summons, warrant, discovery request or similar legal request.

Law Enforcement—We may disclose your relevant PHI to law enforcement when required to do so, such as in response to a court order, court-ordered warrant, subpoena or summons issued by a judicial officer or a grand jury subpoena. We may also disclose your relevant PHI for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors—We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

Organ, Eye and Tissue Donation—We may disclose your PHI to organ procurement organizations or entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissues.

Threats to Health and Safety—We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Specialized Government Functions—If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security and intelligence activities, the Department of State for medical suitability determinations and for protective services of the President or other authorized persons.

Workers' Compensation—We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Emergency Situations—We may disclose your PHI in an emergency situation (or if you are incapacitated or not present) to a family member, close personal friend, authorized disaster relief agency or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

Inmates—If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with healthcare in the following situations:

- To protect your health or safety
- To protect the health or safety of others
- To protect the safety and security of the correctional institution

Research—Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI—We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing—We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes—We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as certain treatment, payment or healthcare operation functions.

INDIVIDUAL RIGHTS

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

Right to Revoke an Authorization—You may revoke your authorization at any time, but the revocation of your authorization must be in writing. The revocation will be effective immediately unless we have already taken actions in reliance of the authorization before we received your written revocation.

Right to Request Restrictions—You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or healthcare operations to a health plan when you have paid for the service or item out-of-pocket in full.

Right to Request Confidential Communications—You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could

endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

Right to Access and Receive Copy of your PHI—You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.

Right to Amend your PHI—You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend.

If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive an Accounting of Disclosures—You have the right to receive a list of instances within the last 6 year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, healthcare operations or disclosures you authorized. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

Right to File a Complaint—If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

200 Independence Avenue, S.W.
Washington, D.C. 20201

or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not take any action against you for filing a complaint.

Right to Receive a Copy of this Notice—You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our website (**SilverSummitHealthplan.com**) or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

CONTACT INFORMATION

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

SilverSummit Healthplan ATTENTION: Privacy Official

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

1-844-366-2880, TTY/TDD 1-844-804-6086, Relay 771

STATEMENT OF NONDISCRIMINATION

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. SilverSummit Healthplan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

SilverSummit Healthplan:

- Provides free aids and services to people with disabilities to communicate effectively with us:
- 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:
- Qualified interpreters
- Information written in other languages

If you need these services, contact SilverSummit Healthplan at 1-844-366-2880, TTY: 1-844-804- 6086, Relay 711. If you believe that 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:

SilverSummit Healthplan Grievance Coordinator

2500 North Buffalo Dr. Drive, Suite 250

Las Vegas, NV 89128

1-844-366-2880, TTY: 1-844-804-6086, Relay 711 Fax 1-855-742-0125

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, 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

Phone: 1-800-368-1019, TTY/TDD 1-800-537-7697

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

Forms

1. Grievance or Appeal Form
2. Concern or Recommendation Form
3. Personal Appeal Representative Form
4. Notification of Pregnancy Form
5. Request to Change My Primary Care Provider Form

GRIEVANCE OR APPEAL FORM

This form is to help you file a grievance or appeal. You can fill it out and send it to us. Or, you may write a letter and include this information in your letter. Please mail this form or your letter to:

SilverSummit Healthplan Member Services	**Behavioral Health appeals:**
2500 North Buffalo Drive Suite 250 Las Vegas, NV 89128 Fax 1-866-694-3734	SilverSummit Healthplan - Appeals 12515-8 Research Blvd Suite 400 Austin, TX 78759 Fax 1-866-714-7991

PLEASE PRINT

Member Name:		
Member ID#:		
Street/PO Box/Apartment #:		
City:	State:	ZIP:
Member Phone Number:		
Tracking Number (if you have one). Found in the upper left hand corner of letter.		
Share information you have about the grievance or appeal:		
Representatives Name (if you name one):		
Member/Representative’s signature:		
Daytime Phone #:	Date:	

- You may file a grievance at any time.
- You must file an appeal within 60 days from the date on the denial letter.

CONCERN OR RECOMMENDATION FORM

This form is to help you share a concern or make a recommendation. We want to hear your ideas! You can fill it out and send it to us. Or, you may write a letter and include this information with your letter.

Please mail this form or your letter to:

SilverSummit Healthplan
ATTENTION: Member Services
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128

Phone 1-844-366-2880, TTY: 1-844-804-6086, Relay 711 • Fax 1-866-694-3734

PLEASE PRINT

Member Name:		
Member ID#:		
Street/PO Box/Apartment #:		
City:	State:	ZIP:
Member Phone Number:		
Share information you have about the concern or recommendation:		
Representatives Name (if you name one):		
Member/Representative's signature:		
Daytime Phone #:	Date:	

PERSONAL APPEAL REPRESENTATIVE FORM

You may have someone else act on your behalf in an appeal. The person you list below will be your representative. We cannot speak with anyone on your behalf until we receive this form. Return to us at:

SilverSummit Healthplan

ATTENTION: Appeals Department
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128

Phone 1-844-366-2880, TTY: 1-844-804-6086, Relay 711 • Fax 1-855-742-0125

I, ______________________________________ want the following person to act
[PRINTED NAME OF MEMBER] for me in my appeal. I understand Personal Health Information related to my appeal may be given to my **appeal representative**.

PLEASE PRINT

1. Name of appeal representative:		
2. Address of appeal representative:		
Street/PO Box/Apartment #:		
City:	State:	ZIP:
Daytime Phone ( ):	Evening Phone ( ):	
3. Brief description of the appeal for which appeal representative will be acting on your behalf:		
4. Member signature [SIGNATURE OF MEMBER, PARENT OR GUARDIAN•]		
*Relationship to Member: ☐ Self ☐ Parent ☐ Guardian	Date:	
5. Appeal representative signature {SIGNATURE OF APPEAL REPRESENTATIVE*]		
*Relationship to Member:	Date:	

Notification of Pregnancy Form (side 1)

PLEASE PROVIDE

Notification of Pregnancy Form (side 2)

PLEASE PROVIDE

Request to Change My Primary Care Provider Form

PLEASE PROVIDE

Glossary of Terms

- **Appeal -** A request for your managed care organization to review a denial or a grievance again.
- **Complaint -** A grievance that you communicate to your health insurer or plan.
- **Copayment -** A fixed amount (for example, $15) you pay for a covered health-care service, usually when you receive the service. The amount can vary by the type of covered health-care service.
- **Durable Medical Equipment (DME) -** Equipment and supplies ordered by a health-care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.
- **Emergency Medical Condition -** An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.
- **Emergency Medical Transportation -** Ground or air ambulance services for an emergency medical condition.
- **Emergency Room Care -** Emergency services you get in an emergency room.
- **Emergency Services -** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- **Excluded Services -** Health-care services that your health insurance or plan doesn't pay for or cover.
- **Grievance -** A complaint to your health insurer or plan.
- **Habilitation Services and Devices -** Health-care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.
- **Health Insurance -** A contract that requires your health insurer to pay your covered health-care costs in exchange for a premium.
- **Home Health Care -** Health-care services a person receives in a home.
- **Hospice Services -** Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
- **Hospitalization -** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
- **Hospital Outpatient Care -** Care in a hospital that usually doesn't require an overnight stay.

- **Medically Necessary -** Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
- **Network -** The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health-care services.
- **Non-participating Provider -** A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider, instead of a participating provider. In limited cases such as there are no other providers, your health insurer can contract to pay a non-participating provider.
- **Participating Provider -** A provider who has a contract with your health insurer or plan to provide covered services to you.
- **Physician Services -** Health-care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine provides or coordinates.
- **Plan -** A benefit, like Medicaid, to pay for your health-care services.
- **Pre-authorization -** A decision by your health insurer or plan before you receive it that a health-care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or pre-certification. Preauthorization isn't a promise your health insurance or plan will cover the cost.
- **Premium -** The amount that must be paid for your health insurance or plan.
- **Prescription Drug Coverage -** Health insurance or plan that helps pay for prescription drugs and medications.
- **Prescription Drugs -** Drugs and medications that by law require a prescription.
- **Primary Care Physician -** A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.
- **Primary Care Provider -** A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.
- **Provider -** A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.
- **Rehabilitation Services and Devices -** Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.
- **Skilled Nursing Care -** Services from licensed nurses in your own home or in a nursing home.
- **Specialist -** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
- **Urgent Care -** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

1-844-366-2880
SilverSummitHealthPlan.com

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