2022 EVIDENCE OF COVERAGE

AmeriHealth Caritas North Carolina, Inc.

Individual member health maintenance organization (HMO) policy

This is a legal contract. Please read your policy carefully.

Important cancellation information: Please read the provision entitled "Termination," found on page 14 of this policy.

Thank you for choosing to enroll for coverage with AmeriHealth Caritas North Carolina! When this **Evidence of Coverage** says "we," "us," "our," "health plan," or "plan," it means AmeriHealth Caritas North Carolina and the health plan that it operates known as AmeriHealth Caritas Next. When it says "you," "your," or "yours," it means the **subscriber** and any eligible **dependents**.

This document is a legal contract. It outlines health **benefits** and services, prescription drug coverage, and amounts you will need to pay toward your health care costs as a **subscriber** of AmeriHealth Caritas Next during the **policy** period. It explains how to get coverage for the health care services and prescription drugs you need. **Please read this document carefully and keep it in a safe place.** This document is also available in alternate formats such as Braille, large print, or audio.

We use a **network** of participating **providers** to provide services for you. We will not cover services you receive from **out-of-network providers** except in very limited circumstances described elsewhere in this document. Participating physicians, **hospitals,** and other health care **providers** are independent contractors and are neither our agents nor employees. The availability of any provider cannot be guaranteed, and our **provider network** is subject to change.

Benefits, copayments, or **coinsurance** may change upon renewal of this **policy**. The health plan's **formulary**, pharmacy **network**, and/or provider network may change at any time. Members will receive advance notice of these changes when applicable.

Renewal

This **policy** will renew each year on January 1 of each year if you pay the required premium, unless the policy is terminated earlier by you or by us as described elsewhere in this document. As a regulated insurance product, the plan's **policy** forms, rates, **premium**s, **cost-sharing** arrangements, and other materials are filed each year for approval by the North Carolina Department of Insurance. As such, your **premium**s may increase upon renewal, but we will provide written notice of any increases at least 60 days before the increase goes into effect and only after the North Carolina Department of Insurance has approved the increase.

If you have any questions about this document or how to use your health plan, please feel free to contact our Member Services team at 1-833-613-2262, 8 a.m. – 8 p.m., 5 days a week, for additional information.

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DEFINITIONS OF IMPORTANT WORDS USED IN THIS DOCUMENT

Adverse Benefit Determination -

(1) A denial, reduction, or termination of, or a failure of the Health Plan to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;

(2) a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time); or

(3) a Noncertification.

- **Annual enrollment period** — A set time each fall when members can change their health plan. Generally, the annual enrollment period begins the November prior to the health plan year.
- **Appeal** — An appeal is a disagreement with our decision to deny a request for coverage of health care services or prescription drugs, or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don’t pay for a drug, item, or service you think you should be able to receive.
- **Behavioral health** — The diagnosis and treatment of a mental or behavioral disease, disorder, or condition listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM), as revised, or any other diagnostic coding system, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.
- **Benefit period** — One calendar year or one **plan year**, as applicable per the terms of the **member’s** plan. However, when a **member** is initially enrolled, the **benefit period** will be the date of enrollment through the end of the then-current calendar year.
- **Benefits** — Your right to payment for **covered health services** available under this **policy**.
- **Brand name drug** — A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name **drug**s have the same active-ingredient formula as the generic version of the drug. However, **generic** drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.
- **Certificate of Coverage** – A policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.
- **Clinical Peer** – A health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review
- **Clinical Review Criteria** – the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.

- **Coinsurance** — An amount you may be required to pay as your share of the cost for services or prescription drugs. **Coinsurance** is usually a percentage (for example, 20%).
- **Complication of Pregnancy** — medical conditions whose diagnoses are separate from pregnancy, but may be caused or made more serious by pregnancy, resulting in the mother's life or health being in jeopardy or making a live birth less viable. Examples include:
    - Abruption of placenta;
    - Acute nephritis;
    - Pre-eclampsia or eclampsia;
    - Placenta previa;
    - Poor fetal growth;
    - Kidney infection;
    - Emergency caesarian section, if provided in the course of treatment for a complication of pregnancy.
- **Complaint** — The formal name for making a complaint is "filing a grievance". The **complaint** process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. See also grievance, in this list of definitions. Complaints do not involve coverage or payment disputes; those types of disputes are addressed through the appeals process. (See "appeal" in this list of definitions.)
- **Copayment (or copay)** — A set dollar amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
- **Cost-sharing** — Cost-sharing refers to amounts that a covered person must pay when services or drugs are received. Cost-sharing includes any combination of these types of payments:
    - Any deductible amount a health plan may impose before services or drugs are covered.
    - Any fixed copayment amount that a health plan requires when a specific service or drug is received.
    - Any coinsurance amount, a percentage of the total amount paid for a service or drug that a health plan requires when a specific service or drug is received.
- **Covered Person, Member or You** – A policyholder, subscriber, enrollee, or other individual covered by this health benefit plan.
- **Covered health service** — All of the health care services identified as payable in this **Evidence of Coverage** that are medically necessary and ordered or performed by a provider that is legally authorized or licensed and appropriately credentialed to order or perform the service. With regard to prescription drugs, covered health services mean drugs or supplies used to treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

- **Deductible** — The amount you must pay for health care or prescriptions each year before our health plan begins to pay.
- **Denial of a claim or request for services** means:
  - A denial of a prior authorization for covered benefits.
  - A denial of a request for **benefits** because the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient, or is not provided in or at the appropriate health care setting or level of care.
  - A retroactive rescission or cancellation of coverage that is not due to the failure to pay premiums.
  - A denial of excluded benefits, when evidence is provided that there is a reasonable medical basis that the contractual exclusion doesn't apply.
  - A denial of a request for covered services on the grounds that the treatment or service is experimental or investigational.
- **Department** — The North Carolina Department of Insurance.
- **Dependent** — The **subscriber**'s spouse, domestic partner, or child who resides within the United States.
- **Disenroll or disenrollment** — The process of ending your membership in our health plan. **Disenrollment** may be voluntary (your own choice) or involuntary (not your own choice).
- **Durable medical equipment (DME)** — Certain medical equipment ordered by your **provider** for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetes supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a **provider** for use in the home.
- **Effective date** — The date a member becomes covered under this policy for covered services.
- **Emergency** or **Emergency Medical Condition** – An emergency medical condition is when you, or any other prudent layperson with an average knowledge of health and medicine, reasonably believe that you have acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in (1) placing your health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, this includes if there is inadequate time to safely transfer the woman to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.
- **Emergency Services** – Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.
- **Enrollment Date** – The date of enrollment, or if earlier, the first day of the waiting period for the enrollment

- **Evidence of Coverage (EOC) and disclosure information** — This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our health plan.
- **Formulary/formulary drugs** — A list of medications that we cover. Products that are on the formulary generally cost less than products that are not on the formulary.
- **Foster Child** — unmarried person, under age 26, placed with you or your spouse or domestic partner after assuming the legal obligation for total or partial support;
- **Generic drug** — A prescription drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as the brand name drug. Generally, a generic drug works the same as a brand name drug and costs less.
- **Grievance** – A written complaint submitted by a Covered Person about any of the following:
  a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care services in question is not a grievance if the exclusion of the specific service requested is clearly stated in the Certificate of Coverage.
  b. Claims payment of handling; or reimbursement for services
  c. The contractual relationship between a Covered Person and an insurer
- **Habilitative services** — Health care services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech and language therapy, and other services for people with disabilities in inpatient and/or outpatient settings.

- **Health Benefit Plan** – means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
  a. Accident.
  b. Credit.
  c. Disability income.
  d. Long-term or nursing home care.
  e. Medicare supplement.
  f. Specified disease.
  g. Dental or vision.
  h. Coverage issued as a supplement to liability insurance.
  i. Workers' compensation.

j. Medical payments under automobile or homeowners.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self insurance.

- **Health Care provider** – Any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy.
- **Health Care Services** – Services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- **Home Health Aide** — Provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out prescribed exercises). Home health aides do not have a nursing license or provide therapy.
- **Home health care** — Health care services provided to the member in the home for treatment of an illness or injury by an organization licensed and approved by the state to provide these services.
- **Hospice** — A program for members who have six months or less to live that addresses the physical, psychological, social, and spiritual needs of the member and their immediate family.
- **Hospital** — A facility for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses. **Hospital** does not mean health resorts, spas, or infirmaries at schools or camps.
- **Infertility** — The inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.
- **Inpatient rehabilitation facility** — A facility that provides rehabilitative health services on an inpatient basis, as authorized by law.
- **Insurer** – An entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.
- **Managed Care Plan –** A health benefit plan in which an insurer either (1) requires a covered person to use or (2) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the insurer.
- **Maximum out-of-pocket** amount — The most that you pay out **of** pocket during the calendar year for in-network covered services, including **deductible**s and any cost-sharing. Amounts you pay for your premiums and prescription drugs do not count toward the maximum out-of-pocket amount.

- **Medically Necessary –** Medical Necessity or Medically Necessary means those covered services or supplies that are:
    - Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes
    - Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
    - Within generally accepted standards of medical care in the community o Not solely for the convenience of the insured, the insured's family, or the provider

  For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.
- **Member** (**member** of our health plan, or "health plan member") — A person who is eligible to get **covered health services**, who has enrolled in our health plan, who has paid any necessary premium or on whose behalf any necessary premium has been paid, and whose enrollment has been confirmed. A member includes the subscriber and any dependents.
- **Network** — The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members. They also agree to accept our payment and any health plan costsharing as payment in full.
- **Network pharmacy** — A pharmacy where members of our health plan can get their prescription drug benefits. We call them network pharmacies because they contract with our health plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- **Network provider** — Providers who have an agreement with our health plan to provide covered services to our members and to accept our payment as payment in full. Our health plan pays network providers based on the agreements we have with the providers. Network providers may also be referred to as "health plan providers."
- **Noncertification** – a determination by an Insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is

experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

- **Out-of-network pharmacy** — A pharmacy that doesn't have a contract with our health plan to coordinate or provide covered drugs to members of our health plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our health plan unless certain conditions apply.
- **Out-of-network provider** or **out-of-network facility** — A provider or facility with which we do not have an agreement to coordinate or provide covered services to members of our health plan. Out-of-network providers are not employed, owned, or operated by our health plan and are not under contract with us to deliver covered services to you.
- **Out-of-pocket costs** — See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received or any deductible amount is also referred to as the member's out-of-pocket cost requirement.
- **Partial hospitalization** — Services received from a free-standing or hospital-based program that provides services at least 20 hours per week and continuous treatment for at least three hours but no more than 12 hours per 24-hour period.
- **Participating provider** - a provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the insurer, other than coinsurance, copayments, or deductibles.
- **Plan year** — This is typically a calendar year, but if your initial effective date is other than January 1, your initial plan year will be less than 12 months, starting on the effective date and running through December 31 of the same year.
- **Policy** — The document that describes the agreements between the health plan and the **member**. Your **policy** includes this document, the Summary of Benefits, your application, and any amendments or riders.
- **Premium** — The periodic payment to AmeriHealth Caritas North Carolina or a health care plan for health and/or prescription drug coverage.
- **Primary care provider** — The doctor or other provider (e.g., a physician in family medicine, general medicine, internal medicine, or pediatric medicine; advanced practice nurse; certified nurse practitioner; or physician's assistant) you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she may also talk with other doctors and health care providers about your care and refer you to them.
- **Prior authorization** — Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our health plan.
- **Prosthetics and orthotics** — These are medical devices ordered by your doctor or other health care **provider**. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

- **Provider** - is the general term we use for doctors, other health care professionals, hospitals, and health care facilities that are licensed or certified under Chapter 90 of the North Carolina General Statutes or the laws of another state to provide health care services.
- **Quantity limits** — A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount that we cover per prescription or for a defined period of time.
- **Rehabilitation services** — These services include physical therapy, speech and language therapy, and occupational therapy. Services may be provided on an inpatient or outpatient basis and may be subject to limitations as outlined in the Summary of Benefits.
- **Rider** — An amendment to this Evidence of Coverage that may modify the covered benefits.
- **Service Area** – Service area means the geographic area in North Carolina as described by the HMO pursuant to G.S. 58-67-10(c)(11) where an HMO enrolls persons who either work in the service area, reside in the service area, or work and reside in the service area, as approved by the Commissioner pursuant to G.S. 58-67-20.
- **Sexual Dysfunction** – Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.
- **Skilled nursing facility (SNF) care** — Skilled nursing care and rehabilitation services provided continuously and daily in a skilled nursing facility. Examples of SNF care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.
- **Special enrollment period** — An opportunity to enroll in a health plan outside of the annual open enrollment period based on specific qualifying events.
- **Stabilize** – To provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.
- **Step therapy** — A pharmacy management tool that requires you to first try another drug to treat your medical condition before we will cover the drug your **provider** may have initially prescribed.
- **Subscriber** — The covered person who is not a dependent and who is properly enrolled under this policy, on whose behalf this policy is issued.
- **Summary of Benefits** — A document of coverage that identifies the member, applicable copayments, coinsurance, deductibles, maximum out-of-pocket amount, and benefit limits for covered health services. Any time we issue a new Summary of Benefits, it will replace any prior Summary of Benefits on the effective date of the new Summary of Benefits.

- **Telehealth Services** — Telehealth services include evaluation, management and consultation services for behavioral health and nonemergency medical issues with a professional provider via an interactive audio/video telecommunications system.
- **Urgent care services** — Services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. **Urgent care services** may be furnished by **network providers** or **out-of-network providers** when **network providers** are temporarily unavailable or inaccessible.

- **Utilization Review** - a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

  a. Ambulatory review. - Utilization Review of services performed or provided in an outpatient setting.
  b. Case management. - A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
  c. Certification. - A determination by an Insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for Medically Necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
  d. Concurrent review. - Utilization review conducted during a patient's hospital stay or course of treatment.
  e. Discharge planning. - The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.
  f. Prospective review. - Utilization Review conducted before an admission or a course of treatment including any required preauthorization or precertification.
  g. Retrospective review. - Utilization Review of Medically Necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.
  h. Second opinion. - An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

- **Utilization Review Organization (URO) –** An entity that conducts Utilization Review under a Managed Care Plan but does not mean an Insurer performing Utilization Review for its own Health Benefit Plan.

ELIGIBILITY AND TERMINATION

To be eligible for coverage as a member in our health plan, you must:

- Reside in our service area.
- Not be enrolled in Medicare on your effective date of coverage with us. If we have knowledge of your enrollment in Medicare, we will not issue a policy to you.

Eligible dependents

The following persons may also be eligible to enroll as dependents under this plan:

- Your spouse or domestic partner, as recognized under the applicable marriage or civil union laws of North Carolina, who resides within the service area.
- Your natural child or a legally adopted child.
- Stepchildren.
- Children awarded coverage pursuant to an administrative or court order.
- Foster children.

If you have a child with a mental, physical, or developmental disability who is incapable of earning a living, your child may stay eligible for dependent health benefits beyond age 26 if all of the following are true:

- The child is and remains incapable of earning a living.
- The condition started before the child reached age 26.
- The child was covered under this or any other health plan before the child reached age 26 and stayed continuously covered after reaching age 26.
- The child depends on you for most or all of their support.

For the child to stay eligible, you must provide our health plan and the federal Exchange written proof that the child is mentally, physically, or developmentally disabled, depends upon you for most of their support, and is incapable of earning a living. You have 31 days from the date the child reaches age 26 to do this. We may periodically ask you to confirm that your child's condition hasn't changed, but we will not ask for this confirmation more than one time a year.

We will extend coverage for a child enrolled in a postsecondary educational institution during a medically necessary leave of absence.

When coverage begins

If you are newly enrolled in our health plan and have paid your first month's premium, your coverage will begin on the date listed as the effective date on your member ID card. No health services received prior to the effective date are covered.

If you were previously a member of the health plan in the past 12 months, your premium payments must be up to date for the past plan year before we can renew this policy. If there is any balance due for the prior plan year, any payment you make toward a new or renewing policy

will be applied to that outstanding balance before it is applied to the new policy premium. You must make the first month's premium payment for coverage to begin.

Enrollment periods

You will typically enroll in a plan during the annual enrollment period, which generally runs from November 1 through December 15 each year. During this annual enrollment period, you can also choose to change your health plan.

If you have a change in circumstances, you may be eligible for a special enrollment period within 60 days of that event. Events that may qualify for a special enrollment period include:

- Birth or legal adoption of a child.
- Marriage.
- Loss of other health insurance coverage.
- New loss of, or eligibility for, federal subsidy programs.
- Change in your permanent address.

Enrolling dependents

Dependents who experience a qualifying event as defined by state and federal law can be enrolled into our health plan outside of the open enrollment period during a special enrollment period. A dependent who becomes aware of a qualifying event may enroll during the 60 calendar days before or after the effective date of the event, but coverage won't begin earlier than the day of the qualifying event. If a dependent is not enrolled when they first become eligible, the dependent must wait until the next open enrollment period to enroll unless they enroll under the special enrollment period. This requirement is waived when a parent is required to enroll a child due to an administrative or a court order. Minor children (newborn, foster, adopted) are covered for congenital defects or anomalies. Eligibility for your dependent child will last until the end of the calendar year that the child turns 26.

You must submit an enrollment application requesting coverage for dependents who become eligible after the original policy effective date. The subscriber will be notified of coverage approval, the premium amount, and the effective date of coverage for the dependent. You will need to provide any premium that may be due or any documentation to show the effective date of the qualifying event with the application.

A newborn dependent child of the subscriber is automatically covered for the first 30 days of life. If you want to continue enrollment of the newborn beyond the 31st day, you will need to enroll the newborn within 31 days of the date of birth. If the dependent is a newly adopted child or foster child, the effective date of coverage is the date of the adoption or placement for adoption, or the placement for foster care. An eligible adopted child must be enrolled within 30 days from the legal date of the adoption. A foster child must be enrolled within 30 days from the date of placement in the foster home. If the premium changes because of adding the newborn, foster child or adopted child to your coverage, then you will need to pay the full premium amount for the newborn within 31 days of the date of birth or 30 days of the legal adoption date or placement of the foster child.

Changes in eligibility

You will need to notify us of any changes that might affect your eligibility or the eligibility of any dependents for coverage under this **policy**. Any notification must happen within 60 days of the change, which includes a change in your permanent address or changes with the number of dependents, or changes in age or other insurance coverage that may impact you or your dependents' eligibility. We will extend coverage for a child enrolled in a postsecondary educational institution during a medically necessary leave of absence.

End of coverage — termination of enrollment

If your coverage ends for any of the reasons below, your last day of coverage will be the last day of the month for which you have paid your premium. End of coverage for you will also end coverage for any dependents that may be enrolled in our health plan with you under this policy. If your coverage ends, we will send you written notice 30 days before terminating your coverage. Reasons for ending coverage may include any of the following:

- You give us written notice asking us to cancel this policy for you and/or your dependents. If you have already paid any premiums in advance for any months after the date of termination, we will refund or credit that amount within 30 days of the request for termination. In the case of retroactive terminations, we will not refund or credit any premium when claims have been submitted for dates of service after the requested date of termination.
- Loss of eligibility if you are no longer living in the service area served by our plan.
- For an enrolled dependent, the end of the calendar year in which they turn 26.
- The death of the subscriber, although dependents may continue coverage under a new policy.
- If premiums are not paid when they are due, in which case we will give you 15 days' advance written notice of pending termination prior to ending coverage.
- Discontinuation of this plan, in which case we will give you 90 days' advance written notice before ending coverage.
- Discontinuation of all of our plans in the North Carolina Exchange, in which case we will give you 180 days' advance written notice before ending coverage.
- Fraud, including improper use of your member ID card.

Payment of premiums

Coverage will not begin until the initial premium payment is made. Each premium payment is to be paid on or before its due date.

Premium payments are due in advance for each calendar month. Monthly payments are due on or before the first day of each month for coverage for that month. After paying your first premium, you will have a grace period of 15 days after the next premium due date (three months for those receiving a federal premium subsidy Advance Premium Tax Credit to pay your next premium amount. Coverage will remain in force during the grace period. If we don't receive full payment of your premium within the grace period, your coverage will end as of the last day of the last

month for which a premium has been paid. We will notify the subscriber of the nonpayment of premium and pending termination as well as notify the subscriber of the termination if the premium hasn't been received within the grace period.

For those receiving a federal premium subsidy, we will still pay for all appropriate claims during the first month of the grace period, but may pend claims for services received in the second and third months of the grace period. We will also notify the subscriber of the nonpayment of premiums, and any providers of the possibility of claims being denied when the member is in the second and third months of their grace period, if applicable. We will continue to collect federal premium subsidies from the U.S. Department of the Treasury for the subscriber and any enrolled dependents, but, if applicable, will return subsidies for the second and third months of the grace period at the end of the grace period if the premium amount owed is not paid and coverage ends for the subscriber and any dependents. A subscriber can't enroll again once coverage ends this way unless they qualify for a special enrollment period or during the next open enrollment period.

Reinstatement of coverage

If coverage is ended because of nonpayment of premiums, we may agree to reinstate coverage upon your request and our approval. If we do reinstate coverage, we will only provide benefits for accidental injuries or illnesses that began after the date of reinstatement. In all other respects, the same rights as existed under this policy immediately before the due date of the defaulted premium will remain in effect, including any riders or endorsements attached to the reinstated policy. Any premiums paid in connection with a reinstatement will be applied to a period for which you have not previously paid a premium but will not exceed 60 days prior to the date of reinstatement.

Certificate of creditable coverage

We will provide you with a certificate of creditable coverage when your or your dependent's coverage ends under this policy or you exhaust continuation of coverage. Please keep this certificate of creditable coverage in a safe place. You can also request a certificate of creditable coverage while you are still covered under this policy and for up to 24 months following the end of your coverage by calling our Member Services department.

HOW TO USE YOUR HEALTH PLAN

Our plan uses network providers to provide covered services to you. This means that we will not pay for services you might receive from out-of-network providers unless you have an emergency medical condition or we authorize services from an out-of-network provider because the medically necessary services you need are not available from a network provider. You can find a provider in our network online at

https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&brandCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=NCEXv

or by calling our Member Services number on your member ID card. Network providers are not employees of our plan.

This health plan's benefits are limited to the covered health services included in this policy. What we will pay and any cost-sharing you may need to pay are also outlined in the Summary of Benefits. All covered health services are subject to the limitations and exclusions contained in the exclusions and limitations section of this policy. When Covered Health Services rendered are within the scope of practice of a duly licensed optometrist, podiatrist, licensed clinical social worker, certified substance abuse counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage counselor, or physician assistant, these services are included in your benefits and eligible for reimbursement.

If you use a network provider, the provider will bill us for any covered health services they provide. You will be responsible for paying any deductibles, copayments, and coinsurance as outlined in your Summary of Benefits. You will also be required to pay for any noncovered services.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine Our and Your payment obligations.

Choosing a primary care provider (PCP)

Once you enroll, you and any covered dependents in this plan must choose a PCP. If you do not select one, we will pick one for you. You can also change your PCP if the PCP is no longer a network provider. Your PCP will oversee your care and coordinate services from other network providers when needed. In certain instances, if you have a serious condition or disease, you may be able to select a specialist to serve as your PCP subject to our health plan's approval. You will be allowed to choose a network pediatrician as the PCP for any covered dependents under age 18.

Continuity/transition of care

For 90 days after the effective date of a new member's enrollment (or until treatment is completed, if less than 90 days), we will cover any medical or behavioral health condition currently being treated at the time of the member's enrollment in our plan or honor an existing prior authorization, whichever is of shorter duration. If the member is pregnant and in their second or third trimester, pregnancy-related services will be covered through 60 calendar days postpartum.

If a network provider stops participating in our network and you are in active treatment for a serious condition or illness, you may continue receiving care from that out-of-network provider until treatment for the condition is completed or you change providers to a network provider, whichever comes first. Pregnant members in their second or third trimester of pregnancy and who have started prenatal care with a provider who stops participating in our network can continue receiving prenatal care through 60 days of postpartum care. This continuity of care allowance does not apply to providers who have been terminated for cause as network providers by the plan.

If you are determined to be terminally ill at the time of a provider's termination of participation in our network, or at the time of enrollment under our plan, and the provider was treating your terminal illness before the date of the provider's termination or your new enrollment in our plan, the transitional period shall extend for the remainder of your life with respect to care directly related to the treatment of your terminal illness or its medical manifestations.

Medical necessity

Covered benefits and services under our plan must be medically necessary. We use clinical criteria, scientific evidence, professional practice standards and expert opinion in making decisions about medical necessity. The cost of services and supplies that aren't medically necessary will not be eligible for coverage and won't be applied to deductibles or out-of-pocket amounts.

Prior authorization

Certain services or supplies may need to be reviewed before you receive them to make sure that they are medically necessary and being provided by a network provider. If you are receiving services from a network provider, the provider will be responsible for obtaining any necessary prior authorization (PA) before you receive services. If the PA is denied and the provider still provides you with these services, the provider cannot bill you for these denied services. If you are obtaining services outside of our service area or from an out-of-network provider, you will need to make sure that any necessary PA has been received before receiving services or the service may not be covered under this plan. Coverage will also depend on any limitations or exclusions for this plan, payment of premium, eligibility at the time of service, and any deductible or cost-sharing amounts. If you do not obtain PA before an elective admission to a hospital or certain other facilities, you may face a penalty.

This list of physical or behavioral health services requiring PA is subject to change. For the most up-to-date information, please visit or have your provider visit the PA section of the plan website.

Physical health services requiring prior authorization

- All out-of-network services excluding emergency services.
- All services that may be considered experimental and/or investigational.
- All miscellaneous services.
- Elective air ambulance.
- Inpatient hospital services:
  - All inpatient hospital admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation.
  - Behavioral health.
  - Obstetrical admissions and newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section.
  - Medical detoxification.

- Elective transfers for inpatient and/or outpatient services between acute care facilities.
- Long-term care initial placement (while enrolled with the plan — up to 90 days).

- Gastroenterology services.
- Gender reassignment services.
- Genetic testing.
- Home-based services.
- Home health care (physical, occupational, and speech and language therapy) and skilled nursing (after six combined visits, regardless of modality).
- Home infusion services and injections.
- Home health aide services.
- Private duty nursing (extended nursing services).
- Personal care services, or assistance with activities of daily living including bathing, eating, dressing, toileting, and walking.
- Dental anesthesia.
- Enteral feedings.
- Hospice inpatient services.
- First- and second-trimester terminations of pregnancy require PA and are covered in the following two circumstances: o The member's life would be endangered if she were to carry the pregnancy to term.
  - The pregnancy is the result of an act of rape or incest.
- Private duty nursing.
- Rehabilitation services and habilitative services (chiropractic services and speech and language, occupational, and physical therapy): o Chiropractic services, and speech and language, occupational, and physical therapy require PA after initial assessment or reassessment. This applies to private and outpatient facility-based services.
- Transplants, including transplant evaluations.
- Chemotherapy.
- Clinical trials.
- DME:
  - Items with billed charges equal to or greater than $750.
  - DME leases or rentals and custom equipment.
  - Enteral nutritional supplements.
  - Prosthetics and custom orthotics.
  - All unlisted or miscellaneous items, regardless of cost.
  - Negative pressure wound therapy.

- Hearing aids:
  - Any newly fit monaural hearing aid (PA required over $750).
  - Any replacement hearing aid (PA required over $750).
  - All newly fit binaural hearing aids (PA required over $750).
  - Ear molds (PA required over $750).
  - Battery (PA required over $750).
- Hearing services: o Cochlear and auditory brainstem implant external parts replacement and repair.
  - Soft band and implantable bone conduction hearing aid external parts replacement and repair.
  - Cochlear and auditory brainstem implants.
  - Implantable bone conduction hearing aids (bone-anchored hearing aid BAHA).
- Hyperbaric oxygen.
- Gastric restrictive procedures/surgeries.
- Hysterectomy (Hysterectomy Consent Form required).
- Elective procedures including, but not limited to, joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, and laparoscopic /exploratory surgeries.
- Surgical services that may be considered cosmetic, including:
  - Blepharoplasty.
  - Mastectomy for gynecomastia.
  - Mastopexy.
  - Maxillofacial surgery.
  - Panniculectomy.
  - Penile prosthesis.
  - Plastic surgery/cosmetic dermatology.
  - Reduction mammoplasty.
  - Septoplasty.
  - Breast reconstruction not associated with a diagnosis of breast cancer.
- Bariatric surgery.
- Infertility testing or treatment.
- Cochlear implantation.
- Medically necessary contact lenses.
- Pain management including, but not limited to:
  - External infusion pumps.

  - Spinal cord neurostimulators.
  - Implantable infusion pumps.
  - Radiofrequency ablation.
  - Nerve blocks.
  - Epidural steroid injections.
- Congenital cleft lip and palate oral and facial surgery or orthodontic services.
- Post-mastectomy inpatient care — Note: Inpatient discharge decisions following mastectomy procedures will be made by the attending physician in consultation with the patient. Length of post-mastectomy inpatient stays are based on the unique characteristics of each patient, taking into consideration their health and medical history.
- The following radiology services, when performed as outpatient services, may require PA.
  - Computed tomography (CT) scan.
  - Positron emission tomography (PET) scan.
  - Magnetic resonance imaging (MRI).
  - Magnetic resonance angiography (MRA).
  - Nuclear cardiac imaging.
- Reconstructive breast surgery (following a mastectomy) — Breast reconstruction is covered regardless of the time elapsed between the mastectomy and the reconstruction. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information, please call the number on the back of your AmeriHealth Caritas Next member ID card.

Physical health services that do not require PA

Subscribers and their dependents do not need PA to see a PCP, go to a local health department, or receive services at school-based clinics.

The following services will not require PA:

- Emergency care (in-network and out-of-network).
- 48-hour observation stays (except for maternity — notification required):
  - Low-level plain film X-rays.
  - Electrocardiograms (EKGs).
  - Family planning services.
  - Women’s health care by network providers (OB/GYN services).
  - Routine vision services.

- o Dialysis.
- o Postoperative pain management (must have a surgical procedure on the same date of service).

Behavioral health services requiring PA

- All out-of-network services except emergency care.
- Psychiatric inpatient hospitalization.
- Partial hospitalization.
- Mobile crisis management.
- Professional treatment services in facility-based crisis programs (following the initial seven days/112 units).
- Outpatient opioid treatment.
- Ambulatory detoxification.
- Nonhospital medical detoxification.
- Medically supervised alcohol or drug use treatment center detoxification crisis stabilization/Alcohol and Drug Abuse Treatment Center (ADATC; following first eight hours of admission).
- Electroconvulsive therapy (ECT).
- Psychological testing.

Behavioral health services that do not require authorization

- Mental health or substance dependence assessment.
- Medication-assisted treatment (MAT).
- Psychiatric and substance use disorder outpatient and medication management services:
  - o Adult (age 21 and over) benefit limit is eight units per calendar year.
  - o Children and adolescents (under age 21) requiring more than 16 units per calendar year will require PA.
- Diagnostic assessment.

Utilization management

We use our Utilization Management program to help ensure you receive appropriate, affordable, and high-quality care contributing to your overall wellness. Our Utilization Management program focuses on both the medical necessity and the outcome of physical and behavioral health services, using prospective, concurrent, and retrospective reviews. For all decisions, we will use documented clinical review criteria based on sound clinical evidence that are periodically evaluated to ensure ongoing efficacy. We will obtain all information required to make utilization review decisions, including pertinent clinical information. Retrospective review includes the review of claims for emergency services to determine whether the applicable prudent layperson legal standards have been met.

We will:

1. Routinely assess the effectiveness and efficiency of our utilization review program.
2. Coordinate the Utilization Review program with our other medical management activities, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
3. Provide covered persons and their providers with access to our review staff via a tollfree or collect call phone number whenever any provider is required to be available to provide services that may require prior certification to any plan enrollee. We will establish standards for phone accessibility and monitor phone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that phone service is adequate, and take corrective action when necessary.
4. Limit our requests for information to only that information necessary to certify the admission, procedure, or treatment; length of stay; and frequency and duration of health care services.
5. Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.
6. Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

We will make review decisions after all of the necessary information about the requested service has been received. We may request additional information needed in making a decision and, if so, we will allow you at least ninety (90) days to provide the additional information. If a provider or member fails to release necessary information in a timely manner, we may deny certification of the requested service. Notification of utilization management decisions will be consistent with North Carolina law and our policies. Prospective and concurrent determinations will be communicated to the Covered Person’s provider within three business days after we obtain all necessary information about the admission, procedure, or health care service, as required by NCGS 59-50-61(f).

If we have approved an ongoing course of treatment to be provided over a period of time or number of treatments:

- Any reduction or termination by us of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. We will notify the member of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the member to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

- Any request by a member to extend the course of treatment beyond the period of time or number of treatments, where delay in the decision could reasonably appear to seriously jeopardize the life or health of the member or jeopardize the member's ability to regain maximum function, shall be decided as soon as possible, taking into account the medical exigencies. We will notify the member of the benefit determination, whether adverse or not, within 24 hours after the plan's receipt of the request, provided that any such request is received by the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment shall be made in accordance with this plan.

If we certify a health care service, we will notify the member's provider. For a noncertification, we will notify the member's provider and send written or electronic confirmation of the noncertification to the member. For concurrent reviews, we will be responsible for health care services until the member has been notified of the noncertification (i.e., decertification does not become effective until notice is provided to the covered person). We will decide on retrospective reviews within 30 days of our receipt of the request. We will notify your provider in writing of our decision. If we deny the service as a result of the review, we will send written notice to both you and your provider within five business days after the determination is made. We remain responsible for health care services until you have been notified of the noncertification. We will notify you orally or in writing. To obtain PA or verify requirements for inpatient or outpatient services, including which other types of facility admissions require PA, you or your provider can call us at 1-833-613-2262.

Cost-sharing requirements

In addition to the monthly premium, the amount you will have to pay for covered health services may include a deductible, coinsurance, and copayments. Our contract with network providers for covered services may be at a discounted rate of payment, in which case your deductible and cost-sharing amounts will be based on the discounted rate of payment. Your specific cost-sharing amounts may differ for various services and can be found in your Summary of Benefits.

- Your deductible is the amount you will have to pay each year for covered services before the health plan begins to pay. Any coinsurance or copayment amounts will not apply to your deductible but will count toward your maximum out-of-pocket amount.
- Coinsurance is your share of the cost for covered services or prescription drugs that you pay, usually shown as a percentage.
- A copayment or copay is your share of the cost for covered services or prescription drugs that you pay as a set dollar amount.
- The maximum out-of-pocket amount is the most you will pay out of pocket during the year for covered services. This does not include any amounts you pay for premiums.

COVERED HEALTH SERVICES

This section describes the services for which coverage is available. Please refer to the Statement of Benefits for details about:

- The amount you must pay for these covered health services (including any deductible, copayment, and/or coinsurance).
- Any limits that apply to these covered health services (including visit, day, and dollar limits on services).
- Any limit to the amount you are required to pay in a calendar year (maximum out-of-pocket amount).

Please refer to the how to use your health plan section of this document to see whether services may require PA.

Accident-related dental services

Outpatient and office visit services received for dental work and oral surgery are covered if they are for the initial repair of an injury to the natural teeth, mouth, jaw, or face which results from an accident and are medically necessary. Initial repair for injuries due to an accident means services must be requested within 60 days from the date of injury and be performed within six months of the date of injury and include all examinations and treatment to complete the repair.

Allergy testing and treatment

We cover medically necessary allergy testing and treatment, including allergy shots and serum only when administered by a network provider in an office visit setting.

Ambulance services

We cover ambulance services by ground, air, or water in the event of an emergency. Services must be provided by a licensed ambulance service provider and must take you to the nearest hospital where emergency care can be provided.

We also cover nonemergency ambulance transportation by a licensed ambulance service (either ground, air, or water ambulance) when the transport is:

- From an out-of-network hospital/facility to a network hospital/facility.
- To a hospital that provides a higher level of care than was available at the original hospital/facility.
- To a more cost-effective acute care facility.
- From an acute facility to a subacute facility/setting.

Nonemergency air transportation requires PA.

Autism spectrum disorders (ASDs)

Covered health services include the assessment, diagnosis, and treatment of ASDs including:

- Evaluation and assessment services.

- Behavior training and management and applied behavioral analysis, including, but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers.
- Habilitative or rehabilitation services, including, but not limited to, occupational therapy, physical therapy, or speech and language therapy, or any combination of those therapies.
- Psychiatric care.
- Psychological care, including family counseling.
- Pharmacy services and medication as covered under the terms of this policy.
- Therapeutic care, which includes behavioral analysis and habilitative or rehabilitation services.

Applied behavioral analysis is only covered through age 18. All services for ASD require PA.

Bariatric surgery

Covered health services under this benefit include bariatric surgery that modifies the gastrointestinal tract with the purpose of decreasing weight. Before pursuing bariatric surgery, a complete nutritional, behavioral, and medical evaluation must be completed, and requirements must be met. Bariatric surgery must be medically necessary to be eligible for coverage.

Biofeedback

We will cover medically necessary biofeedback when provided in a medical office setting.

Blood Products

We will cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a Member's own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

We will cover the cost of the collection or obtainment of blood or blood products from a blood donor, including the Member in the case of autologous blood donation.

Bone mass measurement services

We will cover services for bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last bone mass measurement was performed. We may provide coverage for follow-up bone mass measurement more frequently than every 23 months if medically necessary. Bone mass measurement services will only be covered for individuals meeting certain clinical criteria if for a primary diagnosis other than prevention or wellness and will require PA.

Chemotherapy services

We will cover intravenous chemotherapy treatment received as an outpatient service at a hospital or other facility. Covered health services include the facility charge and charges for related supplies and equipment as well as physician services for covered health services.

Complications of Pregnancy

We cover medically necessary services and supplies for treatment of complications of pregnancy.

Congenital cleft lip and palate care and treatment

We will cover medically necessary care and treatment including, but not limited to, oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate; prosthetic treatment such as obturator, speech appliances and feeding appliances; orthodontic treatment and management; prosthodontic treatment and management; otolaryngology treatment and management; audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices and physical therapy assessment and treatment. If a member with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by this plan.

Diabetes services and supplies

We cover the following medically necessary services and supplies for the treatment of diabetes:

- Exams, including diabetic eye examinations and foot examinations.
- Routine foot care.
- Outpatient diabetic education and medical nutrition therapy services ordered by a physician and provided by appropriately licensed or registered health care professionals.
- Diabetes care management and monitoring equipment, including certain supplies that may be covered under your pharmacy benefit.
- Diabetes education.
- Podiatric appliances for the prevention of complications associated with diabetes.
- Insulin pumps and supplies needed for the insulin pumps.

Diagnostic services — outpatient

We cover laboratory, X-ray, and radiology services performed to diagnose disease or injury. Outpatient diagnostic services or imaging may be provided at a hospital, alternate facility, or in a physician's office. Specific diagnostic services related to preventive care can be found in the preventive health care services section below.

Dialysis services — outpatient

We cover dialysis treatments received as an outpatient from a network provider, including outpatient dialysis centers and physician offices.

DME

We cover medically necessary DME ordered or provided by a physician. DME may require PA, and we reserve the right to approve rental instead of purchase of the DME. Examples of DME include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), prosthetics, and

wheelchairs. Please refer to your Summary of Benefits for details and any limitations to coverage.

Emergency services

We will cover services needed to initiate treatment and stabilize your emergency medical condition. These services may include a hospital or facility charge, supplies, and associated professional services. If you are admitted to the hospital from the emergency room, any applicable copay for emergency room services will not apply. If you are admitted to an out-of-network hospital from the emergency room, you must notify us within 24 hours. When you are stabilized, we will transfer you by ambulance to the closest appropriate network hospital or facility. Coverage will only apply if the condition meets the definition of an emergency medical condition, but you do not need to notify us in advance before seeking treatment for an emergency. Emergency services received from an out-of-network provider will be covered at the in-network benefit level.

Family planning services

Family planning services covered under this plan include counseling and education about family planning; injectable contraceptive medication administered by a physician; intrauterine devices, including insertion and removal; and surgical sterilization (vasectomy, tubal ligation). Certain contraceptive medications may be covered under your pharmacy benefit. Please refer to your Statement of Benefits for more information regarding these covered services and any limitations that may apply.

Hearing aids and hearing services

We will cover hearing aids for members under the age of 22 (limited to one hearing aid per ear once every 36 months, subject to prior authorization) and hearing services, including

- Cochlear and auditory brainstem implant external parts replacement and repair.
- Soft band and implantable bone conduction hearing aid external parts replacement and repair.
- Cochlear and auditory brainstem implants.
- Implantable bone conduction hearing aids (bone-anchored hearing aid BAHA).

Prior authorization may be required for hearing services.

Home health care

We will cover certain services received in the home from a certified/licensed home health agency when ordered by a physician. Examples of these services include skilled care, physical/ occupational/speech and language/respiratory therapy, social work services, and home infusion. Services must only be provided on a part-time, intermittent basis and cannot be solely for assisting with activities of daily living. Please refer to your Statement of Benefits for more information and any limitations that may apply.

Hospice care

Hospice care is a comprehensive program of care that addresses the physical, social, and spiritual needs of a terminally ill patient and provides support for the immediate family. Services

will be covered when recommended by a physician and received from an appropriately licensed hospice agency or inpatient hospice program.

Hospital services

This plan covers inpatient hospital services and physician and surgical services for treatment of an illness or injury and associated services and supplies for this care, including anesthesia, subject to prior authorization. Treatment may require inpatient services when they can't be adequately provided on an outpatient basis.

This plan also covers outpatient hospital services for diagnosis and treatment, including certain surgical procedures.

Outpatient hospital services for emergency care are covered per the emergency services section above.

Infertility services

Coverage for infertility includes services provided for the diagnosis, treatment, and correction of any underlying causes of infertility, including coverage of certain prescription drugs. Infertility benefits are limited to three medical ovulation induction cycles per lifetime per member. Artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and services for procurement and storage of donor semen/eggs are not covered.

Mental health and substance use services

Inpatient behavioral health services and substance use services are covered when received in an inpatient or intermediate care setting. Care may be provided in a general or psychiatric hospital, a residential treatment center, or an alternate facility. Substance use services include detoxification and related medical services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation.

We will also cover certain outpatient behavioral health services and substance use services. Examples include:

- Outpatient office visits.
- Outpatient rehabilitation services in individual or group settings.
- Short-term partial hospitalization.
- Diagnostic testing to evaluate a mental condition.
- Day treatment programs.

Coverage applies whether treatment is voluntary on the part of the covered person or courtordered as the result of contact with the criminal justice or legal systems.

Other Provider Office Visits

Office visits with qualifying providers (*e.g.,* Physician Assistant, Nurse Practitioner) for primary care services are covered.

Outpatient Facility Services (*e.g.,* Ambulatory Surgery Center)

We will cover facility charges for covered health services delivered in an outpatient setting for treatment of an illness or injury, including, when applicable, surgical services and associated services and supplies for this care, including anesthesia, subject to prior authorization.

Outpatient Surgery Physician/Surgical Services

We will cover professional fees for covered health services delivered in an outpatient setting, subject to prior authorization.

Pediatric vision services

We cover pediatric vision services through the last day of the month in which a child turns age 19. Covered services include: one comprehensive low vision exam every five years and low vision aids; one routine eye exam per calendar year and one pair of eyeglasses (with standard frames and lenses) or contact lenses per calendar year. Please refer to the Statement of Benefits for additional information and any limitations.

Physician services for sickness and injury

We cover services provided by a physician, including specialists, for the diagnosis and treatment of an illness or injury. Services may be provided in a physician's office, in a free-standing clinic, at the patient’s home, or in a hospital.

Pregnancy services

Covered services include prenatal care, delivery, postnatal care, and services for any related complications of pregnancy. We will cover services including those that may be provided by a certified nurse midwife or a stand-alone birthing center. The minimum duration of a covered inpatient stay for a delivery is 48 hours for the mother and the newborn after a vaginal delivery or 96 hours for the mother and newborn after a cesarean section delivery. Coverage also includes well-baby care in the hospital or birthing center and well-baby office visits. Complications of pregnancy are treated the same as any other illness. An emergency (nonelective) cesarean section is considered a complication of pregnancy.

Prescription drugs

We use a pharmacy benefits management (PBM) organization to help manage your prescription drug benefit, including specialty medications. You will need to obtain your prescription medications from a network pharmacy to obtain coverage. Prescriptions can be filled at either a retail network pharmacy or through our mail-order network pharmacy. As with obtaining any service under our plan, you will need to show your member ID card when you fill or obtain your prescription medications.

The list of prescription drugs covered under this plan is also called a formulary. The formulary covers both brand (preferred and non-preferred) and generic (preferred and non-preferred) medications and will determine what your out-of-pocket costs will be for medications under our plan. The formulary is occasionally subject to change, but we will provide written notice to you before any changes take effect and will work with you and your prescriber to transition to another covered medication if you are on a long-term prescription.

We will also cover certain off-label uses of cancer drugs in accordance with state law. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendia: (1) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendia; (2) The Thomson Micromedex DrugDex, (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Our PBM may also use certain tools to help ensure your safety and so that you are receiving the most appropriate medication at the lowest cost to you. These tools include step therapy, quantity limits, and PA. More information about these tools and the medications they are used for can be found in our formulary and in your Statement of Benefits. Quantity limits will be waived under certain circumstances during a state of emergency or disaster.

Our PBM operates closed formularies (i.e., products not listed are treated as nonformulary or nonpreferred); however, members may still access drugs prior to formulary review as drugs not on the formulary can still be requested, and our PBM's coverage determination and prior authorization process affords opportunity for nonformulary exceptions.

Preventive health care services

We cover any preventive services required by federal and state laws or regulations. Your deductible, copayment, or coinsurance amounts will not apply if these services are received from a network provider.

Federally mandated preventive health care services

Examples of federally required preventive services include, but are not limited to:

- Abdominal aortic aneurysm screening for men ages 65 – 75 who have ever smoked.
- Annual mammogram, Pap test, prostate-specific antigen (PSA) test, colonoscopy, and colorectal cancer screenings.
- Routine immunizations for children, adolescents, and adults who have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Nutritional counseling.
- Preventive care and screenings for infants, children, and adolescents according to guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women according to guidelines supported by HRSA.

The complete list of federally required preventive services can be found at the federal Health Insurance Marketplace website at https://healthcare.gov/coverage/preventive-care-benefits.

Primary Care Office Visits

We cover office visits for primary care and/or to treat an injury or illness are covered.

State-mandated preventive health care services

The State of North Carolina requires that insurers cover the following preventive services:

- Cervical cancer screening — Examination and laboratory tests for early detection and screening including Pap smear, liquid-based cytology, and human papillomavirus detection;

this will follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

- Certain clinical trials as described in North Carolina state law (G.S. 58-3-255).
- Colorectal cancer screening — Annual examinations and laboratory tests for colorectal cancer are covered for any member who is at least age 50 or is younger than age 50 but is at high risk for colorectal cancer.
- Medically necessary care and treatment for medically diagnosed congenital defects and abnormalities, including cleft lip and palate.
- Hospital and anesthesia charges for certain dental procedures for members less than age 19 or for members with physical or mental disabilities if provided by a network hospital or ambulatory surgical center.
- Diagnosis and treatment of lymphedema.
- Mammograms — We cover one baseline mammogram for any female member ages 35 – 39; beginning at age 40, one screening mammogram will be covered per female member per benefit period.
- Newborn hearing screening.
- Certain off-label prescription drugs used for cancer treatment.
- Ovarian cancer screening — For female members ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered.
- PSA test.

Private duty nursing

Covered health services under this section include medically necessary nursing care provided to a patient one on one by licensed nurses in an inpatient or home setting.

Radiation therapy — outpatient

We cover radiation oncology treatment received as an outpatient at a hospital or other facility. Covered health services include facility charges and charges for related supplies and equipment as well as physician services associated with covered health services.

Rehabilitation services

Medically necessary services for rehabilitation services, including cardiac rehabilitation and pulmonary rehabilitation, occupational therapy, and physical therapy must be ordered by a physician and delivered by appropriately licensed medical personnel. We will determine if the service is covered by reviewing both the skilled nature of the service and the need for physician management. We cover semi-private room and board, services, and supplies provided during an inpatient stay in an inpatient rehabilitation facility. Rehabilitation services may also be provided on an outpatient basis.

Covered health services also include chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function when a network chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders on an outpatient basis.

The following are specifically excluded from chiropractic care and osteopathic services:

- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Manipulation under anesthesia.
- Maintenance or preventive treatment consisting of routine, long-term, or not medically necessary care provided to prevent reoccurrences or to maintain the patient's current status.
- Vitamin or supplement therapy.
- Infusion therapy or chelation therapy.

Please refer to the Schedule of Benefits for additional information and any limitations.

Habilitative services

Medically necessary services for habilitative services, including occupational therapy, and physical therapy must be ordered by a physician and delivered by appropriately licensed medical personnel. We will determine if the service is covered by reviewing both the skilled nature of the service and the need for physician management.

Covered health services also include chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function when a network chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders on an outpatient basis.

The following are specifically excluded from chiropractic care and osteopathic services:

- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Manipulation under anesthesia.
- Maintenance or preventive treatment consisting of routine, long-term, or not medically necessary care provided to prevent reoccurrences or to maintain the patient's current status.
- Vitamin or supplement therapy.
- Infusion therapy or chelation therapy.

Please refer to the Schedule of Benefits for additional information and any limitations.

Sexual dysfunction

Coverage by the plan includes certain services related to the diagnosis, treatment, and corrections of any underlying causes of sexual dysfunction resulting from organic disease.

Skilled nursing facility services

We will cover facility and professional services in a **skilled nursing facility** when determined to be **medically necessary**. We cover skilled nursing facility admissions when:

- The skilled nursing facility is a **Network Provider.**
- The admission is ordered by the **Covered Person's** Attending Physician. We require written confirmation from the physician that skilled care is necessary.
- **Covered Services** must be of a temporary nature and must be supported by a treatment plan.

- **Covered Services** do not include custodial, domiciliary care, or long-term care admissions.

Specialist Visits

Office visits for specialty care services are covered.

Telehealth Services

Telehealth services from approved TBA Provider are covered at $0 cost share. Telehealth services from any other professional provider are covered, subject to the same cost sharing and out of network limitations as the same health care services when delivered to a member in person. You can check with your provider to see if telehealth services are available.

Transplantation services

We will cover organ and tissue transplants when ordered by a physician, approved through PA, and when the transplant meets the definition of a covered health service (and is not an experimental, investigational, or unproven service). We may require that transplant services be provided at a Center of Excellence facility. Covered transplant services include services related to donor search and acceptability testing of potential live donors. If the donor is not a member under this policy, donor costs directly related to organ removal are covered health services for which benefits are payable through the member organ recipient's coverage under this policy. We do not cover organ donor expenses for a recipient other than a member enrolled on the same family policy. Reasonable costs for travel and lodging may be reimbursed for a covered transplant based on our guidelines that are available upon request from us.

Temporomandibular joint (TMJ) disorder

Covered services under this policy include medically necessary services for the treatment of a disorder of the TMJ or any bone or joint of the face or head resulting from an accident, trauma, congenital or developmental defect, illness, or pathology. Diagnosis and treatment of TMJ disorder must be recognized by the medical or dental profession as effective and appropriate for TMJ disorder.

Coverage is not provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.

Urgent care services

Covered health services include medically necessary services by a network provider, including facility costs and supplies. Your preventive health care services benefits with $0 cost-sharing may not be used at an urgent care center. You should first contact your PCP for an appointment before seeking care from another network provider, but network urgent care centers can be used when an appointment with your PCP is not available.

EXCLUSIONS AND LIMITATIONS

Covered health services must be administered by a network provider and be medically necessary for diagnosis or treatment of an illness or injury or be covered under the preventive health care services section of this policy for a benefit to be paid.

This plan does not cover the following:

- Any services not identified as a covered health service under this policy; you will be responsible for payment in full for any services that are not covered health services.
- Expenses, fees, taxes, or surcharges imposed by a provider or facility that are actually the responsibility of the provider or facility.
- Any covered health service, supply, or device that would otherwise be at no cost in the absence of coverage by this policy.
- Any experimental or investigational treatments or unproven services.
- Treatment received outside the United States, except for a medical emergency while traveling in accordance with the emergency services section of this policy.
- Any medical and/or recreational use of cannabis or marijuana.

In no event will benefits be provided for covered health services under the following circumstances:

- Services or supplies are provided prior to the effective date or after the termination date of this policy, except as noted under the eligibility and termination section of this policy.
- For the reversal of sterilization or vasectomies.
- For abortion, unless necessary to save the life or health of the member, or as a result of incest or rape.
- For fetal reduction surgery.
- For expenses related to television, phone, or expenses for other persons.
- For standby availability of a medical provider when no treatment is rendered.
- For dental services. We will inform members of the availabilities of stand-alone pediatric dental plans during the plan selection and enrollment process.
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this policy or for correction of a birth defect in a child.
- For behavioral health services related to:
  - Testing for evaluation and diagnosis of learning abilities.
  - Premarital counseling.
  - Court-ordered services required for parole or probation.

    - Testing for aptitude or intelligence.

- For employment-related diagnostic testing, laboratory procedures, screenings, or examinations.
- For services related to surrogate parenting.
- For nontraditional alternative or complementary medicine not consistent with conventional medicine. These include, but are not limited to, acupuncture; hydrotherapy; hypnotism; and alternative treatment modalities including, but not limited to, boot camp, equine therapy, wilderness therapy, and similar programs.
- For treatment of injuries sustained while participating in organized collegiate sports, professional or semiprofessional sports, or other recreational activities for which the subscriber and/or dependent is paid to participate.

GRIEVANCES AND APPEALS

Sometimes AmeriHealth Caritas Next may decide to deny or limit a request your provider makes for you for benefits or services offered by our plan. To keep you satisfied, we provide processes for filing appeals or complaints. You have the right to file a complaint, file an appeal, and right to an external review.

Our grievances and appeals processes are in place to address concerns you may have with a service issue, quality of care, or the denial of a claim or request for service. In general, any concern regarding quality of care or service is considered a grievance. Concerns related to the denial of a claim or request for service are considered appeals.

Grievances

You, your authorized representative, or your provider can file a grievance with us at any time and can do so in writing or over the phone. The **Grievance** process is voluntary, and our process provides for both first and second-level grievance reviews. If you need help with filing a **grievance**, we will help walk you through the process, including providing help with completing forms, providing interpreter and translation services, or providing TTY support.

Grievance procedure — First-level review

A standard **grievance** should be submitted to us by you or your authorized representative by phone at 1-833-613-2262 or in writing at:

Member Grievances

PO Box 7415

London, KY 40742-7415

Upon filing your grievance, please include any information you believe supports your case. We will carefully consider the issue(s) you have raised, and we will never charge you anything to file a grievance. Filing a grievance will also never affect your benefits. You may submit written material for the first level of review, and we will provide you with the name, address, and phone number of the Grievance Coordinator and instructions for submitting written materials within three business days of receipt of your grievance. However, you may not attend the first level of review.

Once we have received your grievance, we will send you written acknowledgement of receipt within three business days of receiving it. For grievances concerning quality of care, we will send you acknowledgement within 10 business days of receiving it, advising you that we have referred the grievance to our Quality Improvement Committee for review and resolution and that state law does not allow for a second-level review for grievances concerning quality of care.

A written complaint submitted by a member about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in this policy.

After we research your concern, we will send you and, if applicable, your authorized representative a written notice on how your concern has been resolved. In most instances, we will provide you with this written notice within 30 calendar days of receiving your grievance. On

rare occasions, you or we may ask for an additional 14 calendar days for resolution, especially if more information is needed that would be helpful to resolving your grievance. We will notify you verbally of any extension and send you written notice within two calendar days explaining the reason for the extension.

If our decision is not in your favor, the written notice will contain:

- The qualifications of the person or persons who reviewed your grievance.
- A statement from the reviewers summarizing the grievance.
- The reviewers' decision in clear terms and the basis for the decision, written in clear terms.
- A reference to any documentation used as a basis for the decision.
- A statement advising you of your right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance.
- Notice of the availability of assistance from Health Insurance Smart NC, including the phone number and address of the program.

Grievance procedure — second-level review

If you are dissatisfied with our response to the first-level grievance, you or your provider acting on your behalf may submit additional information, including written comments, records, or documents, along with a letter requesting a second-level review of your grievance to the address below:

Member Grievances

PO Box 7415

London, KY 40742-7415

You may also submit these documents via fax to 1-833-887-2262.

Within 10 days of receiving your request for a second-level review, we will provide you with information on the grievance process and your rights. We will also send you the name, address, and phone number of the grievance review coordinator when they have been determined. For the second-level review, you (or your representative) have the right to present your case to the review panel, and you may submit additional material before or during the review meeting. You have the right to ask questions of any member of the review panel, as well as the right to be represented or assisted by a person of your choosing, including a family member, employer representative, or attorney.

Your grievance will be reviewed by the review panel. The review panel will schedule a review meeting within 45 days after receiving your request for a second-level review. We will notify you of the date of the review meeting, in writing, at least 15 days before the meeting takes place. Your right to a full review will not be conditioned on attendance of the review meeting.

We will make our decision and notify you and your provider in writing within seven business days of the review meeting. This notification will include the professional qualifications and licensure of the review panel members, a statement of the review panel's understanding of your grievance, and the review panel's recommendation and rationale along with a description of the evidence that was considered. We will also include any clinical rationale (if the review is of a clinical matter). Our written notification regarding your second-level grievance will include:

- The qualifications and licensure of the members of the review panel.
- A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
- A description of or reference to the evidence or documentation considered by the review panel.
- If reviewing a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, used by the review panel.
- The rationale for our decision if it differs from the review panel's recommendation.
- A statement that the decision is our final determination in the matter. If the review concerned a noncertification and our decision on the second-level grievance review is to uphold our initial noncertification, a statement advising you of your right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
- Notice of the availability of the Commissioner's office for assistance, including the phone number and address of the Commissioner's office.
- Notice of the availability of assistance from Health Insurance Smart NC, including the phone number and address of the program.

The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at 1201 Mail Service Center, Raleigh, NC 27699 or by phone at 1-800-546-5664.

At any time, you can request free copies of all records and other information we have relevant to your written grievance, including the name of any health care professional we consulted. To obtain copies, please contact Member Services at 1-833-613-2262.

Grievance procedure — expedited review

If your grievance regards a decision or action on our part that could significantly increase risk to your life, health, or ability to regain maximum function, please call Member Services immediately to file an expedited grievance. We will notify you orally of the determination within 72 hours after receipt of the expedited review request. We will then send written confirmation to you within three business days.

You may request expedited review of the first- or second-level grievance. You may request an expedited review of the second-level grievance review regardless of whether any initial review was expedited. Expedited reviews will meet all requirements of non-expedited reviews as

described in our grievance procedures and in accordance with NCGS 58-50-62(f), (g), and (h) with changes to the time table.

When you are eligible for an expedited second-level review, we will conduct the review proceeding and communicate the decision within four days after receiving all necessary information. The review meeting may take place by way of a phone conference call or through the exchange of written information.

Standard appeals

You or your authorized representative can file an appeal of an Adverse Benefit Determination verbally by calling Member Services at 1-833-613-2262 or in writing to PO Box 7419, London, KY 40742-7419. An appeal must be filed within 180 days from the date of our written notice denying your claim or your request for service. The appeal procedure is voluntary on the part of the member and an appeal may be initiated and/or proposed by the member or a person acting on behalf of the insured such as a relative or other representative, including his/her provider. Unless you are requesting an expedited appeal, a verbal appeal must be followed up with a written and signed appeal. When you make a verbal appeal, we will let you know how to file a signed written appeal. We will also help you with filing the written appeal if you need assistance.

> Verbal appeals: The date you make your verbal appeal counts as the date of receipt of your appeal, but we will not be able to investigate your appeal until we have received your signed written appeal. We will send you written notice acknowledging receipt of your verbal appeal within five calendar days. If we don't receive your signed written appeal within 180 calendar days of the adverse benefit determination, we are not required to process your appeal. We will attempt to contact you five calendar days before this 180-day period expires to remind you to send us the written appeal. If we still do not receive your written appeal before this deadline, we will send you a written notice within five calendar days of our inability to process your verbal appeal.

Once we have received your written appeal, we will begin researching your appeal. Within three business days after receiving a request for a standard, non-expedited appeal, we will provide you with the name, address, and phone number of the coordinator and information on how to submit written material. You or your authorized representative will be allowed to access any medical records or other documents that we have that are related to the subject of the appeal at no cost to you. The physician reviewing your appeal will not have been involved in the previous decision on your claim or request for service and will have the appropriate training in your condition or disease.

You will have the opportunity to provide evidence in support of your appeal by phone, in writing, or in person. Once we have made a decision on your appeal, we will send you written notice of the decision no later than 30 calendar days after receiving your appeal. If your appeal concerns continuation of a service that you are currently receiving, you can continue receiving the services being appealed until (1) the end of the approved treatment period or (2) the determination of the appeal. Any appeals of noncertification appeal determinations will enter the grievance process as second-level grievances.

You may be financially responsible for the continued services if the appeal is not approved. You can request continued services by calling Member Services at 1-833-613-2262 (TTY 1-844-214-

2471). Note: You cannot request an extension of services after the original authorization has ended. For more details, please contact Member Services.

Expedited appeals

An expedited appeal can be requested by you or your authorized representative. An expedited appeal will be made available when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Your provider can also file a verbal request for expedited appeal. We will not require written follow-up for a verbal request for expedited appeal. We may require documentation of the medical justification for an expedited appeal.

We will send you written notice acknowledging the receipt of the request for an expedited appeal within 24 hours of receiving the request. If we deny the request for the appeal to be processed in an expedited manner, we will handle the request as a standard appeal and will send written notice to you or your authorized representative that we have denied your request for an expedited appeal.

We will, in consultation with a medical doctor licensed to practice medicine in North Carolina, provide expedited review and communicate the decision in writing to covered members and their providers as soon as possible, but not later than four days after receiving the information justifying expedited review. If the expedited review is a concurrent review determination, we will remain liable for the coverage of health care services until the covered person has been notified of the determination. We are not required to provide an expedited review for retrospective noncertifications.

You or your authorized representative may access any medical records or other documents that we have and that are related to the subject of the expedited appeal at no cost to you. The physician reviewing your appeal will not have been involved in the previous decision on your claim or request for service and will have the appropriate training in your condition or disease.

You will have the opportunity to provide evidence in support of your appeal by phone, in writing, or in person. When we have made a decision on your appeal, we will try to notify you verbally of our decision within 72 hours of receiving the expedited appeal request.

Independent External Review

North Carolina law provides for review of noncertification decisions by an external, Independent Review Organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. We will notify you in writing of your right to request an external review each time you: receive a noncertification decision

- receive an appeal decision upholding a noncertification decision

In order for your request to be eligible for external review, the NCDOI must determine the following:

- that your request is about a medical necessity determination that resulted in a noncertification decision;

- that you had coverage with us in effect when the noncertification decision was issued;
- that the service for which the noncertification was issued appears to be a covered service under your policy; and
- that you have exhausted our internal review process as described below

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, you will be considered to have exhausted the internal review process if you have:

- completed our appeal and received a written determination from us, or
- received notification that we have agreed to waive the requirement to exhaust the internal second level grievance process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed our internal review process and received a written final determination.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving our written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of our written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

- the name and contact information for the Independent Review Organization (IRO) assigned to your case;
- a copy of the information about your case that we have provided to the NCDOI;
- notice that we will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 after receipt of the notice of acceptance.

If you choose to provide any additional information to the IRO, you must also provide that same information to us at the same time using the same means of communication (e.g., you must fax

the information to us if you faxed it to the IRO). When faxing information to us, send it to 1-844-412-7890. If you choose to mail your information, send it to:

AmeriHealth Caritas Next
PO Box 7419
London, KY, 40742-7419

Please note that you may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and to us. The NCDOI will forward this information to the IRO and us within two business days of receiving your additional information.

The IRO will send you written notice of its determination within 45 days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the noncertification, we will, reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by us at the time we receives notice of the IRO's decision to reverse the noncertification, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written or verbal request to the NCDOI for an expedited review after you:

- receive a noncertification decision from us AND file a request for an expedited appeal, or
- receive an appeal decision upholding a noncertification decision, or

You may also make a request for an expedited external review if you receive an adverse appeal decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if our internal review process was already completed, or (2) require the completion of our internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to you within 3 days of the date the NCDOI received your request for an expedited external review. If the IRO's decision is to reverse the noncertification, we will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested

service or supply that is the subject of the noncertification decision. If you are no longer covered by us at the time we receives notice of the IRO's decision to reverse the noncertification, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on us and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which you have already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOI at:

Via Internet: https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax)919-807-6865

In Person:
NC Department of Insurance

Albemarle Building
325 N. Salisbury St.
Raleigh, NC 27603
855-408-1212 (toll-free)

Smart NC for External Review information and Request Form

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an appeal or grievance with their health plan.

To be included in the section of letter that explains expedited appeal and 2nd level grievance:

If you believe you are eligible for and request an expedited appeal, you may be eligible to request an expedited external review from NCDOI. Expedited external review is available if you have a medical condition where the time frame for completion of an expedited appeal with us would reasonably be expected to seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

CLAIMS AND REIMBURSEMENT

Claims

AmeriHealth Caritas is not liable under this policy unless proper notice is furnished to you or someone acting on your behalf that covered services have been rendered to a member.

Network provider claims

The network provider is responsible for filing all claims in a timely manner. You will not be responsible for any claim that is not filed on a timely basis by a network provider. If you provide your insurance card to a network provider at the time of service, the provider will bill us directly for claims incurred, and, if covered, we will reimburse your provider directly.

Out-of-network provider claims

Your or your provider are required to give notice of any claim for services rendered by an out-of-network provider. No payment will be made for any claims filed by a member for services rendered by an out-of-network provider unless you give written notice of such a claim to AmeriHealth Caritas within 180 days of the date of service. Failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for you to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Member, later than one year from the time submittal of the claim is otherwise required.

To give notice of a claim, please call us at the phone number listed on your member ID card to obtain a claim form. You must sign the claim form before we will issue payment to a provider or reimburse you for covered services received under this policy. You must complete a claim form for services rendered by an out-of-network provider and submit it, together with an itemized bill and proof of payment, to AmeriHealth Caritas Next, 200 Stevens Drive, Philadelphia, PA 19113.

Reimbursement

Reimbursement will be made only for covered services received in accordance with the provisions of this policy. In the event you are required to make payment other than a required copayment, deductible, or coinsurance amount at the time covered services are rendered, we will ask that your **provider** reimburse you, or we will reimburse you by check.

Claim forms

When we receive the notice of claim, we will direct you to where you can access a claim form or send you a claim form by mail if you request it.

All claims submitted by your provider will be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner, whether submitted in writing or electronically.

Time of payment of claims

After receiving a claim form, we will either make a request for additional information or make a coverage decision within 30 calendar days.

Payment of claims

Benefits will be paid to you. We may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless you direct otherwise in writing by the time claim forms are filed. We cannot require that the services are rendered by a particular health care services provider, except that the provider must be in-network where possible.

Unpaid premium

At the time of payment of a claim under this plan, any premium then due and unpaid may be deducted from the claim payment.

MEMBER RIGHTS AND RESPONSIBILITIES

Member rights

A member has the right to:

- Receive information about the health plan, its benefits, services included or excluded from coverage policies, and network providers' and members' rights and responsibilities; written and web-based information that is provided to the member must be readable and easily understood.
- Be treated with respect and be recognized for their dignity and right to privacy.
- Participate in decision-making with providers regarding their health care; this right includes candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. The member has a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations regarding our member rights and responsibilities policies by contacting Member Services in writing.
- Choose providers, within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information; the member also has the right to have access to their medical record in accordance with applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, or source of payment.
- Formulate advance directives; the plan will provide information concerning advance directives to members and providers and will support members through our medical recordkeeping policies.
- Obtain a current directory of network providers, upon request; the directory includes addresses, phone numbers, and a listing of providers who speak languages other than English.
- File a complaint or appeal about the health plan or care provided with the applicable regulatory agency and receive an answer to those complaints within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization; the member also has the right to know that their provider cannot be penalized for filing a complaint or appeal on the member's behalf.
- Members with chronic disabilities have the right to obtain assistance and referrals to providers who are experienced in treating their disabilities.

- Have candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage, in terms that the member understands, including an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the member is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the member's medical record. The plan does not direct providers to restrict information regarding treatment options.
- Have available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency conditions.
- Call 911 in a potentially life-threatening situation without prior approval from the plan, and to have the plan pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger the member, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands.
- Receive prompt notification of terminations or changes in benefits, services, or the provider network.
- Have a choice of specialists among network providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Member responsibilities

A member has the responsibility to:

- Communicate, to the extent possible, information that the plan and network providers need to care for them.
- Follow the plans and instructions for care that they have agreed on with their providers; this responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand their health problems and participate in developing mutually agreed-on treatment goals to the degree possible.
- Review all benefits and membership materials carefully and follow health plan rules.
- Ask questions to ensure understanding of the provided explanations and instructions.
- Treat others with the same respect and courtesy they expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

GENERAL PROVISIONS

Entire policy

This policy, including an application for coverage and any enrollment forms, amendments, riders, and endorsements, and a Summary of Benefits, if any, constitutes the exclusive and entire contract of insurance between you and the health plan, and shall be binding upon all covered persons; the health plan; and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add to, or otherwise modify the express written terms of this contract. There are no warranties, representations, or other agreements between you and us in connection with the subject matter of this plan, except as specifically set forth herein.

Modifications

This contract may not be modified, amended, or changed, except in writing and signed by an officer of AmeriHealth Caritas North Carolina Inc. or the person designated by an officer of AmeriHealth Caritas North Carolina Inc. No employee, agent, or other person is authorized to interpret, amend, modify, waive, or otherwise change this contract or any of its provisions. Notwithstanding the foregoing, we have the right to and may modify or otherwise change the terms and conditions of the contract to make periodic administrative modifications. We will notify you in writing of any changes to this contract.

Non-waiver

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

Conformity with state laws

Any term of this policy that is in conflict with North Carolina law or with any applicable federal law that imposes additional requirements beyond what is required under North Carolina law will be amended to conform with the minimum requirements of such law.

Nondiscrimination

AmeriHealth Caritas North Carolina Inc. does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, genetic information, or health status in the administration of the plan, including enrollment functions and benefit determinations.

Continuation of benefit limitations

Some of the benefits in this policy may be limited to a specific number of visits and/or subject to a deductible. You will not be entitled to any additional benefits if your coverage status should change during the year. All benefits used under your previous coverage status will be applied toward your new coverage status.

Protected health information (PHI)

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

We protect all oral, written, and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. Our Notice of Privacy Practices describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://www.amerihealthcaritasnext.com/about/contact.aspx or call our Member Services team at 1-833-613-2262.

Our relationship with providers

Network providers are not our agents or employees. We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in our network, and we pay benefits. Network providers are independent providers who run their own offices and facilities. We are not liable for any act or omission of any provider.

HOW TO CONTACT US

Method	Member Services — contact information
CALL	1-833-613-2262 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., Monday to Friday
TTY	1-844-214-2471 Calls to this number are free.
FAX	1-844-201-6792
WRITE	Mailing address: 200 Stevens Drive, Philadelphia, PA 19113
WEBSITE	https://www.amerihealthcaritasnext.com/about/contact.aspx

Language assistance and alternate formats:

Assistance is available at no cost to help **members** communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English.
- Written information in alternative formats such as large print.
- Assistance with reading our website.

To ask for help with these services, please call the Member Services number on your member ID card.

Spanish (US):

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese (S):

注意：如果您讲中文，我们可以为您提供免费的语言协助服务。请拨打您 ID 卡上的会员服务电话号码。

Vietnamese:

LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số Dịch vụ Hội viên trên thẻ ID của quý vị.

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 있는 회원 서비스 번호로 전화하십시오.

French (FR):

REMARQUE : si vous parlez français, des services d’assistance linguistique gratuits sont à votre disposition. Appelez le numéro des services aux membres, qui figure sur votre carte d’identification.

Arabic:

ت ب ه: إذا كنت تتحدث اللغة الع ة، ف مكنك االستعانة خدمات المساعدة اللغ ة دون مقا ل . اتصل برقم خدمات األعضاء المدون ع

طاقة التع ف الخاصة ك .

Hmong:

UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.

Russian:

ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Службу работы с клиентами по телефону, указанному в Вашей идентификационной карте.

Tagalog:

PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo para sa wika. Tawagan ang numero ng Mga Serbisyo sa Miyembro na nasa inyong ID kard. **Japanese:**

注記：日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。ID カード に記載のメンバーサービス電話番号までお電話ください。

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter der auf Ihrer ID-Karte aufgeführten Telefonnummer für Mitgliederdienstleistungen an.

Gujarti:

યાન આપો: જો તમે અંગ્ે િસવયા્ની અન્ કોઈ ભયાષયા બોલો છો, તો તમયારયા મયાટે ભયાષયા િહયા્ િવે યાઓ સનઃશલ પર કૉલ કરો. ક ઉપલ ધ છે. તમયારયા આઈડી કયા પર રહલ યા િદ ની િવે યાઓનયાં નબર

Hindi:

ान द: ् दद आप अं ेजी करे अलयावया कोई अन् भयाषया बोलतरे ह, तो आपकरे ललए मुफ़त म भयाषया सहयात् या सरेवयाएं उपल ह। आपकरे आईडी कया पर ददए गए सदस् सरेवया नंबर पर कॉल कर। **Laotian:**

ໂປດຊາບ: ຖາທານເວົ້ າພາສາອ່ ນ , ການບໍ ລິ ການຊວຍເຫຼືອ ດານພາສາທ່ ີ ບ່ ນອກາຈາກພາສາອງກດ

Mon-Khmer:

ប់ រម្មណ៍៖ បបសិនបេបើេ កអ្នកនិ យ េប ង បបេ ពី អង់េប្លស េ ៈបស ជំនួយ េ យឥត្ិតេថ្ល ើ្ នសប ប់េ កអ្នក។ សូមទូរស័ព្ទ េបខបស បបបេមើ ស ជិកែដេ នេ េបេើកាតស េ់របស់េ កអ្នក។

Persian Farsi:

برای این . در صورتی که ﻪب زبانی غیر از انگلیسی صحبت کنیدمی خدمات کمکی زبانی ﻪب رایگانطور برای
شما وجود دارد:ﻪتوج منظور با شماره خدمات اعضای موجود روی
کارت شناسایی خود تماس بگیرید

4813-6644-7606, v. 5

AmeriHealth Caritas North Carolina, Inc.
8041 Arco Corporate Drive
Raleigh, NC, 27617

AMENDMENT TO THE EVIDENCE OF COVERAGE

This amendment applies to the Evidence of Coverage with the form number listed below. This change becomes effective January 1st, 2023.

ACNC Ind NC PY22 - EOC - 20210430

A. The header of the Evidence of Coverage has been amended to change the plan year from 2022 to 2023 effective January 1st, 2023, and reads as follows:

   2023 Evidence of Coverage for AmeriHealth Caritas North Carolina Inc.

B. The cover page of the Evidence of Coverage has been amended to change the plan year from 2022 to 2023 effective January 1st, 2023, and reads as follows:

   2023 EVIDENCE OF COVERAGE

C. The definition of AmeriHealth Caritas Next Telemedicine is added to the Evidence of Coverage and reads as follows:

   AmeriHealth Caritas Next Telemedicine — The preferred vendor who we have contracted with to provide **telemedicine services** to our **members**. Our preferred vendor contracts with **providers** to render **telemedicine services** to our members.

D. The definition of Investigational or Experimental is added to the Evidence of Coverage and reads as follows:

   Experimental or **Investigational** — Services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by AmeriHealth Caritas Next:

   - A drug or device that cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration and has not been granted such approval on the date the service is provided.
   - The service is subject to oversight by an Institutional Review Board.
   - No reliable evidence demonstrates that the service is effective in clinical diagnosis, evaluation, management, or treatment of the condition.
   - The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
   - Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

   Note: Reliable evidence includes but is not limited to reports and articles published in authoritative peer-reviewed medical and scientific literature and assessments and coverage recommendations published by AmeriHealth Caritas Next for Clinical Effectiveness.

E. The definition of Foster Child in the Evidence of Coverage is changed to read as follows:

Foster Child — A minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

F. The definition of Telehealth services in the Evidence of Coverage has been amended to change the term "Telehealth" to "Telemedicine" and reads as follows:

Telemedicine Services — **Telemedicine services** include evaluation, management and consultation services for behavioral health and nonemergency medical issues with a professional provider via an interactive audio/video telecommunications system.

G. The section entitled "HOW TO USE YOUR HEALTH PLAN" in the Evidence of Coverage has been amended to add the following statement:

AmeriHealth Caritas Next plans comply with the provisions of the No Surprises Act of the 2021 Consolidated Appropriations Act and any associated rules or regulations that the Centers for Medicare and Medicaid Services (CMS) or other regulatory authorities may issue. The **member** will not be penalized and will not incur out of network benefit levels unless participating providers able to meet the **member's** health needs are reasonably available without unreasonable delay or the **member** agrees to sign over their rights. The **member** will not be charged for balance bills for out-of-network care (emergency services or care by a non-participating provider at an in-network facility) without the informed consent of the **member** or prior authorization. If the **member** receives incorrect information from AmeriHealth Caritas Next about a provider's network status they will only be responsible for the in-network cost share. If a **provider** or health care facility leaves our network, AmeriHealth Caritas Next will continue to cover **covered health services** at the **member's** in-network cost share for 90 days.

H. Hearing aids and hearing services in the section entitled "COVERED HEALTH SERVICES" of the Evidence of Coverage has been amended to remove the age limitation to read as follows:

We will cover one hearing aid per ear once every 36 months and hearing services including:

- Cochlear and auditory brainstem implant external parts replacement and repair.
- Soft band and implantable bone conduction hearing aid external parts replacement and repair.
- Cochlear and auditory brainstem implants.
- Implantable bone conduction hearing aids (bone-anchored hearing aid [BAHA]).

Prior authorization may be required for hearing services.

I. The "COVERED HEALTH SERVICES" section of the Evidence of Coverage has been amended to add an optional healthy rewards program and reads as follows:

Healthy rewards program

AmeriHealth Caritas Next makes available to you an optional healthy rewards program which allows you to earn incentives and rewards for completing different activities at no cost to you. These

incentives and rewards are available to you as long as you are active on this **policy**. If you have a medical condition or health factor which makes it difficult to complete any of the program's activities, you may still receive your reward by requesting a waiver. The waiver will require you to provide a note from your physician advising you are unable to complete the specified activity due to a medical condition or health factor. You may contact the Member Services phone number on the back of your member ID card for additional information about the waiver process. If your coverage ends under this **policy**, all incentive and rewards under this program will also end. Benefits offered under this program are in addition to the benefits described in this **policy** and certain terms and conditions may apply. You may get additional information on the healthy rewards program by contacting the Member Services phone number on your member ID card. Please note this is an incentive and rewards program and it does not offer any rebates, discounts, abatements or credits, or a reduction of premiums.

J. State-mandated preventive health care services in the section entitled "COVERED HEALTH SERVICES" of the Evidence of Coverage has been amended to change the age requirement for coverage of colorectal cancer screenings from age 50 to age 45 and reads as follows:

Colorectal cancer screening — Annual examinations and laboratory tests for colorectal cancer are covered for any **member** who is at least age 45 or is younger than age 45 but is at high risk for colorectal cancer.

K. Routine Foot Care has been added as a benefit under the section entitled "COVERED HEALTH SERVICES" of the Evidence of Coverage, and reads and follows:

Routine foot care

We cover medically necessary routine foot care including but not limited for treatment of diabetes, metabolic disorders, neurologic disorders, and peripheral vascular disease.

L. Telehealth services in the section entitled "COVERED HEALTH SERVICES" of the Evidence of Coverage has been amended to change the term "Telehealth" to "Telemedicine" and modify language to read as follows:

Telemedicine services

Telemedicine services through **AmeriHealth Caritas Next Telemedicine** are covered at $0 cost share if you receive services via telemedicine through an **in-network provider** that currently offers the service via telemedicine. Certain specialty services including pediatrics are not eligible for **AmeriHealth Caritas Next Telemedicine. Telemedicine services** from any other professional **provider** are covered, subject to the same **cost-sharing** and **out-of-network** limitations as the same **health care services** when delivered to a **member** in-person. You can check with your **provider** to see if **telemedicine services** are available.

M. The "COVERED HEALTH SERVICES" section of the Evidence of Coverage has been amended to add an optional Weight Watchers program and reads as follows:

Weight Watchers program

AmeriHealth Caritas Next makes available to members between the ages of 15 and 64 vouchers for membership with Weight Watchers for up to 28 weeks at no cost. If your coverage ends under this **policy**, all membership voucher benefits will also end. The membership offered is in addition to the benefits described in this **policy** and certain terms and conditions may apply. You may get additional information on the Weight Watchers program by contacting the Member Services phone number on your member ID card.