2023 EVIDENCE OF COVERAGE

AmeriHealth Caritas VIP Next, Inc.

Individual Member Health Maintenance Organization (HMO) Policy

This is your contract with AmeriHealth Caritas VIP Next, Inc. Please read it carefully.

Important cancellation information: Please read the provision entitled "Eligibility and Termination," found on page 19 of this policy.

Thank you for choosing to enroll for coverage with AmeriHealth Caritas VIP Next! When this **Evidence of Coverage** document says "we," "us," "our," "health plan," or "plan," it means AmeriHealth Caritas VIP Next, Inc. 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 your contract with us. Sometimes we refer to it as a "**policy.**" It outlines what **health care services** and prescription drugs your insurance covers and the amount you will need to pay toward their costs during the period of your **policy**. 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. You have 10 days from the date of receipt of this **policy** to examine its provisions and surrender the **policy**, for any reason, to AmeriHealth Caritas Next.

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**, **deductible,** or **coinsurance** may change on 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 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 Delaware Department of Insurance. As such, your **premium**s may increase on renewal, but we will provide written notice of any increases at least 60 days before the increase goes into effect and only after the Delaware Department of Insurance has approved the increase.

If you have any questions about this document, how to obtain alternate formats of this document, or how to use your health plan, please feel free to contact our Member Services team at 1-833-590-3300, 8 a.m. – 8 p.m., 5 days a week.

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Definitions of Important Words Used in This Document

- **Adverse Benefit Determination —** A coverage determination by **the health benefit plan** 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 **health benefit plan's** requirements for **medical necessity**, appropriateness, health care setting, level of care or effectiveness, or the prudent layperson standard for coverage of **emergency services** due to an **emergency medical condition** per Delaware law, and coverage for the requested service is therefore denied, reduced, or ended; or
  - The **health benefit plan** will not provide or make payment based on a determination of the member's eligibility to participate in a plan; or
  - Coverage has been rescinded (whether or not the rescission has an adverse effect on any particular benefit at that time).
- **Allowed amount** – The amount we pay a **provider** for a **covered health service** provided to a **member.** It is the lesser of the **provider's** charge or our maximum payment amount. If you need to pay a **coinsurance,** it is a percentage of the **allowed amount.**
- **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**.
- **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 —** A disagreement with our **Adverse Benefit Determination** 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 determination to stop services that you are receiving. For example, you may ask for an **appeal** if we do not pay for a drug, item, or service you think you should be able to receive.
- **Applied behavior analysis —** The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. These include, but are not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
- **Autism spectrum disorder (ASD) —** As defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems.
- **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 (DSM), as revised, or any other diagnostic coding system. This applies 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**, applied 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 made and sold by the pharmaceutical company that originally researched and developed the drug. **Brand name drugs** have the same active-ingredient formula as the generic version of the drug. However, **generic drugs** are made and sold by other drug manufacturers. These drugs are generally not available until after the patent on the **brand name drug** has expired.
- **Center of Excellence —** A **Center of Excellence** is a team, shared facility, or entity, that provides leadership, best practices, research, and support, and/or training for a focus area. AmeriHealth Caritas Next evaluates transplant programs throughout the U.S. AmeriHealth Caritas Next only includes transplant programs that meet our strict Centers of Excellence criteria in our Network. We annually re-evaluate programs to ensure the network maintains its standards of care.
- **Chronic care management services —** Services provided to **members** who have 2 or more medical conditions expected to last at least 12 months or until the death of the **member**, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Services must be provided in accordance with the Chronic Care Management Services Program, as administered by the Centers for Medicare and Medicaid Services.
- **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 the necessity and appropriateness of **health care services** and supplies. They are based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy.
- **Clinical trials —** Includes **clinical trials** that are approved or funded by use of the following entities:
  - One of the National Institutes of Health (NIH);
  - An NIH cooperative group or center which is a formal **network** of facilities that collaborate on research projects and have an established NIH-approval peer review

program operating within the group, including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

- The federal Departments of Veterans' Affairs or Defense.
- An institutional review board of an institution in this State that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH.
- A qualified research entity that meets the criteria for NIH Center Support grant eligibility.

- **Coinsurance —** A percentage of the **allowed amount** you need to pay for **covered health services** and prescription drugs. A **copayment** is not a **coinsurance**. **Copayment** is defined elsewhere in this document.
- **Complaint —** The formal name for making a **complaint** is "filing a **grievance**". The **complaint** process is only used for certain types of problems. These include problems related to quality of care, waiting times, and the customer service you receive (see "**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.)
- **Complication of pregnancy —** Medical conditions whose diagnoses are separate from pregnancy. They may be caused or made more serious by pregnancy. They may also put the mother's life or health in jeopardy or make a live birth less viable. Examples include:
  - Abruption of placenta.
  - Acute nephritis.
  - **Emergency** caesarean section, if provided in the course of treatment for a **complication of pregnancy**.
  - Kidney infection.
  - Placenta previa.
  - Poor fetal growth.
  - Preeclampsia or eclampsia.
- **Copayment (or copay) —** A specific dollar amount you may need to pay as your share of the **allowed amount** for **covered health services** or prescription drugs you receive. 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. A **copayment** is not a **coinsurance**. **Coinsurance** is defined elsewhere in this document.
- **Cost-sharing —** Amounts that a **covered person** must pay when services or drugs are received. **Cost-sharing** includes any combination of these types of payments:

  - 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.
  - 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.

- **Covered health service — Health care services** that are payable under this **Evidence of Coverage.** They must be **medically necessary** and ordered or performed by a **provider** who is legally authorized or licensed and appropriately credentialed to order or perform the service. **Covered health services** include things such as a medical service or supply, doctor's visit, **hospital** visit, or prescription drug. For prescription drugs, **covered health services** mean drugs or supplies to treat medical conditions, such as disposable needles and syringes when dispensed with insulin.
- **Covered person, member or you —** A policyholder, **subscriber**, enrollee, or other individual covered by this **health benefit plan**.
- **Deductible —** The amount you must pay for **covered health services** or prescription drugs each year before your **health benefit plan** begins to pay.
- **Department —** The Delaware Department of Insurance.
- **Dependent —** The **subscriber's** spouse, domestic partner, or child by blood or by law who is less than 26 years of age who resides within the United States. "Child" includes a biological child, an adopted child, or a child placed for adoption or foster care who is younger than 18 years of age on the date of the adoption or placement for adoption or foster care.
- **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 and supplies ordered by your **provider** for medical reasons. Examples include:
  - Crutches
  - Diabetes supplies
  - Hospital beds ordered by a **provider** for use in the home.
  - IV infusion pumps
  - Nebulizers
  - Oxygen equipment
  - Power mattress systems
  - Speech-generating devices

- Walkers
- Wheelchairs

- **Effective date —** The date a **member** becomes covered under this **policy for covered health 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 mean:
  - Placing your health (or, for a pregnant person, the health of the person or their unborn child) in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

  For a pregnant person having contractions, this includes if there is inadequate time to safely transfer the person to another **hospital** before delivery, or if that transfer may pose a threat to the health or safety of the person or 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 **coverage information —** This document, your enrollment form, and any other attachments, **Schedule of Benefits, riders**, or other optional coverage selected, that explains your coverage. It explains your rights, what we must do, and what you must do as a **member** of our health plan.

- **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.

- **Final internal adverse benefit determination (Final Determination)** – An **Adverse Benefit Determination** that has been upheld by us and completes our internal **appeal** process.
- **Formulary/formulary drugs —** A list of medications that we cover. Products are on the **formulary** generally cost less than products that are not on the **formulary**.
- **Foster Child —** A minor over whom a guardian has been appointed by the clerk of superior court of any county in Delaware. This can also be a minor for whom a court of competent jurisdiction has ordered a guardian the primary or sole custody.
- **Generic drug —** A recognized drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as a **brand name drug**. Generally, a **generic drug** works the same as a **brand name drug** and costs less.
- **Grievance —** A **complaint** submitted by a **covered person** about:
  - An **insurer's** decisions, policies, or actions related to availability, delivery, or quality of **health care services**. A **complaint** submitted by a **covered person** about a decision rendered only because that the **health benefit plan** has a **benefits** exclusion for the **health care services** in question is not a **grievance** if the exclusion of the service requested is clearly stated in the **Evidence of Coverage**.
  - Claims payment and handling or reimbursement for services
  - 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 or outpatient settings.
- **Health benefit plan —** Any of the following if offered by an **insurer**:
  - Accident and health insurance policy or certificate
  - Nonprofit hospital or medical service corporation contract
  - Health maintenance organization **subscriber** contract
  - 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. Sometimes it is called a "health plan."

Health benefit plan also does not mean any of the following kinds of insurance:

- Accident
- Adult and **dependent** dental coverage
- Adult vision coverage
- Coverage issued as a supplement to liability insurance
- Credit
- Disability income
- **Hospital** income or indemnity
- Insurance implemented or administered by the State Health Plan for Teachers and State Employees
- 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
- Long-term or nursing home care
- Medical payments under automobile or homeowners
- Medicare supplement
- Specified disease
- Workers' compensation

- **Health care provider** or **provider—** Any person who is licensed, registered, or certified under state laws or the laws of a state to provide **health care services** in the ordinary care of business, practice, or profession or in an approved education or training program. This can also mean a pharmacy or a health care facility as defined in the laws of Delaware, to operate as a health care facility.
- **Health care services —** Services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- **Hearing aid —** Any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices such as FM systems.
- **Home health aide —** A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing,

or prescribed exercising). **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. Services limited to 100 visits per **benefit period**.
- **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.
- **Iatrogenic infertility —** An impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.
- **Infertility —** A disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:
  - Absent or incompetent uterus.
  - Damaged, blocked, or absent fallopian tubes.
  - Damaged, blocked, or absent male reproductive tract.
  - Damaged, diminished, or absent sperm.
  - Damaged, diminished, or absent oocytes.
  - Damaged, diminished, or absent ovarian function.
  - Endometriosis.
  - Hereditary genetic disease or condition that would be passed to offspring.
  - Adhesions.
  - Uterine fibroids.
  - **Sexual dysfunction** impeding intercourse.
  - Teratogens or idiopathic causes.
  - Polycystic ovarian syndrome.
  - Inability to become pregnant or cause pregnancy of unknown etiology.
  - Two or more pregnancy losses, including ectopic pregnancies.
  - Uterine congenital anomalies, including those caused by diethylstilbestrol (DES).

- **Inherited metabolic diseases —** Diseases caused by an inherited abnormality of biochemistry. This includes any diseases for which the state screens newborn babies.
- **Inpatient rehabilitation facility —** A facility that provides inpatient rehabilitation health **services**, as authorized by law.
- **Insulin pump —** A small, portable medical device that is approved by the FDA to provide continuous subcutaneous insulin infusion.
- **Insurer —** An entity that writes a **health benefit plan** and that is any of the following:
  - An insurance company
  - A service corporation
  - A health maintenance organization
  - A multiple employer welfare arrangement.
- **Low protein modified formula or food product —** A formula or food product that is specially formulated to have less than 1 gram of protein per service, and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. This does not include a natural food that is naturally low in protein.
- **Managed care plan —** A **health benefit plan** in which an **insurer** either requires a **covered person** to use or 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**.
- **Medical formula or food —** Intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements and restrictions have been established by medical research and formulated to be consumed or administrated enterally under the direction of a physician.
- **Medically necessary or medical necessity —** The **covered health services** or supplies that are:
  - Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not for **experimental**, **investigational**, or for cosmetic purposes, except as allowed under Delaware law.
  - 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.
  - Not only 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 receive **covered health services**, after their enrollment has been confirmed and any necessary **premiums** have been paid. A **member** includes the **subscriber** and any **dependents**.
- **National Coverage Determination Services —** A service, item, test, or treatment which has been determined to be covered nationally by the Secretary of the U.S. Department of Health and Human Services.
- **Network or in-network —** Health care professionals, medical groups, **hospitals**, health care facilities, and **providers** who have agreed to provide **covered health services** to our **members**. They also have agreed to accept our payment and any **cost-share** the member pays as a full payment.
- **Network or in-network pharmacy —** A pharmacy that has an agreement with our **health benefit plan** to provide prescription drugs and other items to our members. They agree to accept our payment and any **member** cost-share as a full payment. In most cases, your prescriptions are covered only if they are filled at one of our **network pharmacies**.
- **Network or in-network provider** or **network/in-network facility — Providers** who have an agreement with our health plan to provide **covered health services** to our **members** and to accept our payment and any **member** cost-share as a full payment. Our health plan pays **network providers** based on the agreements we have with them. **Network providers** may also be referred to as "**health plan providers**."
- **Out-of-network pharmacy —** A pharmacy that does not have an agreement with our health plan to provide covered prescriptions or other items to our **members**. Under 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 that does not have an agreement with us to coordinate or provide **covered health services** to **members** of our health plan. They have also not agreed to accept our payment and any **member** cost-share as a full payment. **Out-of-network providers** are not employed, owned, or operated by our health plan.
- **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 called the **member's out-of-pocket cost** requirement.
- **Out-of-pocket maximum** amount **—** The most that you pay out-of-pocket during the calendar year for **in-network covered health services**, including **deductibles** and any **cost-sharing** amounts you have paid. Amounts you pay for your **premiums** do not count toward the **out-of-pocket maximum** amount.
- **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 has an agreement with an **insurer** or an **insurer's** contractor or subcontractor, to provide **health care services** to **covered persons**. In return, the **provider** receives direct or indirect payment from the **insurer**. This payment does not include **coinsurances**, **copayments**, or **deductibles**. This **provider** also agrees to accept the payment and any **member cost-sharing** as a full payment.
- **Physician —** A person duly licensed (other than an intern, resident, or house physician) as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, optometrist, ophthalmologist, physician assistant or licensed doctoral psychologist legally entitled to practice within the scope of his or her license and who normally bills for his or her services.
- **Placement for adoption** or **being placed for adoption —** The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with a person terminates upon the termination of such legal obligations.
- **Plan year —** This is typically a calendar year. However, if your initial **effective date** is other than January 1, your initial **plan year** will be less than 12 months. It will then start on the **effective date** and run through December 31 of the same year.
- **Policy —** The document that describes the agreements between the **health benefit plan** and the **member**. Your **policy** includes this document, the **Schedule of Benefits**, your application, and any amendments or **riders**. Sometimes your **policy** is called a contract.
- **Premium —** The periodic payment to AmeriHealth Caritas Next or a health care plan for health and/or prescription drug coverage.
- **Prescription insulin drugs —** A drug containing insulin that is dispensed under federal and state law for the treatment of diabetes.
- **Primary care provider (PCP) —** The doctor or other **provider** you see first for most health problems. This provider can be a physician in family medicine, general medicine, internal medicine, or pediatric medicine; advanced practice nurse; certified nurse practitioner; or physician's assistant. They make sure you get the care you need for your best health. They may also talk with other **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 **in-network provider** gets **prior authorization** from your **health benefit plan**.
- **Prosthetics and orthotics —** 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 eyes
- Artificial limbs;
- Devices to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.
- Prostheses following mastectomy

- **Provider —** A general term we use for doctors, other health care professionals, **hospitals**, and health care facilities licensed or certified under state law 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 we cover per prescription or for a defined time frame.
- **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 subject to limitations as described in the **Schedule of Benefits**.
- **Rider —** An amendment to this **Evidence of Coverage** that may modify the covered **benefits**.
- **Routine patient care costs for clinical trials —** All items or **covered health services** that are otherwise generally available to a **covered person** that are provided in a **clinical trials** except the following:
  - The **investigational** items or service itself.
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients.
  - Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- **Schedule of Benefits —** A document that identifies the **member,** applicable **copayments**, **coinsurance**, **deductibles**, **out-of-pocket maximum**, and benefit limits for **covered health services**. If we issue a new **Schedule of Benefits**, it will replace any prior **Schedule of Benefits** on the **effective date** of the new **Schedule of Benefits**. A **Schedule of Benefits**, together with the **Evidence of Coverage**, riders, and other documents that amend the **Evidence of Coverage** make up your benefit plan **policy**.
- **Service area — Service area** means the geographic area in Delaware as described by the HMO 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. Visit our website to see our coverage map of counties in our **service area**: www.amerihealthcaritasnext.com/de. You may also contact our Member Services team at

1-833-590-3300, 8 a.m. – 8 p.m., 5 days a week, for additional information.

- **Sexual dysfunction —** Any of a group of sexual disorders that cause inhibition either of sexual desire or the psychophysiological changes that are usually part of 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 such as birth, adoption, divorce, or marriage.
- **Stabilize —** To provide medical care appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, per the Health Care Financing Administration (HCFA) interpretative guidelines, policies, and regulations for responsibilities of **hospitals** in **emergency** cases. These are as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd. They include **medically necessary** services and supplies to maintain stabilization until the person is transferred.
- **Standard fertility preservation services —** Procedures consistent with established medical practices and professional guidelines published by professional medical organizations, including the American Society for Clinical Oncology and the American Society for Reproductive Medicine.
- **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 properly enrolled under this **policy**, and on whose behalf this **policy** is issued. It does not include **dependents.**
- **Telemedicine Services —** Includes evaluation, management and consultation services for **behavioral health** and nonemergency medical issues with a **provider** via an interactive audio or video telecommunications system.
- **Therapeutic equivalents —** A contraceptive drug, device, or product that is all of the following:
  - Approved as safe and effective.
  - Pharmaceutically equivalent to another contraceptive drug, device, or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendia or other applicable standards

of strength, quality, purity, and identity.

- Assigned, by the FDA, the same therapeutic equivalence code as another contraceptive drug, device, or product.

- **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 **in-network providers** are temporarily unavailable or inaccessible.

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

  - Ambulatory review — **Utilization review** of outpatient services.

  - Case management — A coordinated set of activities for individual patient management of serious, complicated, protracted, or other health conditions.

  - Certification — A determination by an **insurer** or its designated **Utilization Review Organization (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.

  - Concurrent review — **Utilization review** during a patient's **hospital** stay or course of treatment.

  - 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.

  - Prospective review — **Utilization review** before an admission or a course of treatment including any required preauthorization or precertification.

  - Retrospective review — **Utilization review** of **medically necessary** services and supplies after services have been provided to a patient. It includes the review of claims for **emergency services** to determine whether the prudent layperson standard has been met per Delaware law.

    - Retrospective review does not include a review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment

  - Second opinion — A clinical evaluation by a **provider** other than the **provider** originally recommending a service. This is 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 not 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, Medicaid, or any other insurance policy, on your **effective date** of coverage with us. If we have knowledge of your enrollment in Medicare, Medicaid, or any other policy, 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 Delaware, who resides within the **service area**.
- Your natural child or a legally adopted child who is less than 26 years of age.
- 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 self-sustaining employment by reason of intellectual disability or physical handicap.
- 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 on 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 has not changed. We will not ask for this confirmation more than one time a year.

Per all applicable requirements of Public Law 110-381, known as Michelle's Law, 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 before 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 per Delaware and federal law and regulation. 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 will not 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. 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**. 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. 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. Coverage includes services due to injury or sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and routine care furnished any infant from the moment of birth. 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. We will provide **benefits** to your adopted child under the same terms and conditions that apply to naturally born **dependent** children, irrespective of whether the adoption has become final when your adopted child's coverage becomes effective. 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. These changes include but are not limited to the following:

- Change in your permanent address.
- Change in your phone number.
- Change of marital status.
- Change in **dependent** status (including changes with the number of **dependents**).
- Changes in age.
- You or your **dependent** obtain other insurance coverage that may impact you or your **dependents**' eligibility, such as job-based a health plan through an employer or a program like **Medicare**, Medicaid, or Children's Health insurance Program.

If there are changes to your marital status, upon the entry of a valid decree of divorce between the **subscriber** and the insured spouse, the divorced spouse is entitled to have issued to him or her, without evidence of insurability, on application made to the **insurer** within sixty days following the entry of the decree, and upon payment of the appropriate **premium**, an individual **policy** of **accident** and health insurance.

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** who 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 ending 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. For 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.
- For non-dependents covered under a child only **policy**, the end of the calendar year in which they turn 21.
- The death of the **subscriber**, although **dependents** may continue coverage under a new **policy**.
- Loss of eligibility of an enrolled spouse **dependent** due to legal separation or termination of marriage by divorce or annulment or similar actions.
    - Loss of eligibility begins on the date a final decree of divorce, annulment or dissolution of marriage is entered between the **dependent** spouse and **subscriber** or the date a termination of domestic partnership between the **subscriber** and domestic partner is entered.
- If **premiums** are not paid when they are due. In this case we will give you 15 days' advance written notice of pending termination before 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 Delaware 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. A grace period of 15 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. If you are receiving a federal **premium** subsidy

Advance Premium Tax Credit your grace period will be 3 months, and your coverage will remain in force during the grace period. If we do not 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. We will also 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**. We will notify 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**. However, if applicable, we 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** cannot 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 you or your **dependents'** 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 after the end of your coverage. To do so, call Member Services at the number listed on your member ID card.

How To Use Your Health Plan

Our plan uses **network providers** to provide **covered health 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**. If we authorize **out-of-network** services your cost share responsibility will be at your **in-network** cost share unless otherwise stated in your **Schedule of Benefits**. You can find a **network provider** online through our on-line **provider** directory at https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&brandCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=DEEXv. You can also call our Member Services number on your member ID card or provided at the end of this document in **How To Contact Us**. **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 **Schedule 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 service**s 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, advanced practice nurse, or physician assistant, these services are included in your **benefits** and are eligible for reimbursement.

You can see any **in-network** specialist you choose without a referral. 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 **Schedule of Benefits**. You will also be required to pay for any non-covered health services.

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 an **in-network provider**. If we authorize out-of-network services your cost share responsibility will be at your **in-network** cost share.

NOTICE: Your actual expenses for **covered health services** may exceed the stated **coinsurance** percentage or **copayment** amount because actual **provider** charges may not be used to determine your and our payment obligations.

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.

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 been diagnosed with a serious or chronic degenerative, disabling, or life-threatening condition or disease, you may select a specialist to serve as your **PCP** subject to our health plan's approval. The specialist must have expertise in treating your disease or condition and be responsible for and capable of providing and coordinating your primary and specialty care. If we determine that your care would not be appropriately coordinated by that specialist, we may deny access to that specialist being chosen as a **PCP**. You will be allowed to choose an **in-network** pediatrician as the **PCP** for any covered **dependents** younger than age 18.

Continuity/transition of care

Subject to **prior authorization** and **medically necessary** criteria review, 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 **out-of- network covered health services** with your treating **provider** for any medical or **behavioral health** condition currently being treated at the time of the **member's** enrollment in our plan, 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 an **in-network provider** stops participating in our **in-network,** they become an **out-of-network provider**. If you are in active treatment for a serious condition or illness when this occurs, 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. We will notify you when your **in-network provider** becomes an **out-of-network provider**. The **out-of-network provider** that is treating you is prohibited from billing you more than your **in-network** cost-share for up to 90-days after you are notified.

In order to receive these services you must obtain **prior authorization** from the **health benefit plan**. Pregnant **members** in their second or third trimester of pregnancy and who have started prenatal care with a **provider** who stops participating in our **in-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 when your **provider** stops participating in our **network**, or at the time you enroll in our plan, and your **provider** was treating your terminal illness before the date of the **provider's** termination or your new enrollment in our plan, you can continue to receive care from that **provider**. However, this is only true for services that directly relate to the treatment of your illness or its medical manifestations.

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 are not **medically necessary** will not be eligible for coverage and will not be applied to **deductibles** or out-of-pocket amounts.

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 are not **medically necessary** will not be eligible for coverage. They will not 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** before you receive services. If the **prior authorization** is denied and the **provider** still provides you with these services, the **provider** cannot bill you for these denied services unless you agreed to receive services at a self-pay rate. 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 **prior authorization** has been received before receiving services. If you do not, the service may not be covered under this plan.

Prior authorization can be retracted after **emergency services** are provided if you or your **provider** materially misrepresented your condition. 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 **prior authorization** before an elective admission to a **hospital** or certain other facilities, you may be responsible for all charges related to services that fail to meet **prior authorization** requirements.

This list of physical or **behavioral health** services needing **prior authorization** is subject to change. For the most up-to-date information, please visit or have your **provider** visit **the prior authorization** 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
- Bariatric surgery
- Chemotherapy
- Cochlear implantation
- Congenital cleft lip and palate oral and facial surgery or orthodontic services

- Dental anesthesia
- **Durable Medical Equipment (DME)**:
  - All unlisted or miscellaneous items, regardless of cost
  - **DME** leases or rentals and custom equipment
  - Items with billed charges equal to or greater than $750
  - Negative pressure wound therapy
  - Prosthetics and custom orthotics
- Air Ambulance is covered only when no other means of travel is appropriate
- Elective procedures including, but not limited to, joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, and laparoscopic or exploratory surgeries
- First- and second-trimester terminations of pregnancy require **prior authorization** and are covered in the following two circumstances:
  - 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
- Gastric restrictive procedures or surgeries
- Gastroenterology services
- Genetic testing
- **Hearing aids**:
  - Any newly fit monaural **hearing aid** (**prior authorization** required over $750)
  - Any replacement **hearing aid** (**prior authorization** required over $750)
  - All newly fit binaural **hearing aids** (**prior authorization** required over $750)
- Hearing services:
  - 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)
- Home-based services
- **Home health aide** services
- **Home health care services** - Including, but not limited to, physical therapy, occupational therapy, speech and language therapy, and skilled nursing services. **Prior authorization** is required after any combination of six **home health**

care service visits are received to allow coverage for any additional home health care services

- Home infusion services and injections
- **Hospice** inpatient services
- Hyperbaric oxygen
- Hysterectomy (Hysterectomy Consent Form required)
- **Infertility** testing or treatment
- Inpatient **hospital** services:
  - All inpatient **hospital** admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation
  - Elective transfers for inpatient and/or outpatient services between acute care facilities
  - Medical detoxification
  - Obstetrical admissions and newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section
- **Medically necessary** contact lenses
- Pain management including, but not limited to:
  - Epidural steroid injections
  - External infusion pumps
  - Implantable infusion pumps
  - Nerve blocks
  - Radiofrequency ablation
  - Spinal cord neurostimulators
- Personal care services, or help with activities of daily living including bathing, eating, dressing, toileting, and walking
- Post mastectomy inpatient care
- Private duty nursing (extended nursing services)
- Reconstructive breast surgery (following a mastectomy)
- **Rehabilitation services** and **habilitative services** (speech and language, occupational, and physical therapy):
  - Speech and language, occupational, and physical therapy require **prior authorization** after initial assessment or reassessment. This applies to private and outpatient facility-based services
- Skilled nursing care
- Surgical services that may be considered cosmetic, including:

  - Blepharoplasty
  - Breast reconstruction not associated with a diagnosis of breast cancer
  - Mastectomy for gynecomastia
  - Mastopexy
  - Maxillofacial surgery
  - Panniculectomy
  - Penile prosthesis
  - Plastic surgery/cosmetic dermatology
  - Reduction mammoplasty
  - Septoplasty
- The following radiology services, when performed as outpatient services, may require **prior authorization**
  - Computed tomography (CT) scan
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiography (MRA)
  - Nuclear cardiac imaging
  - Positron emission tomography (PET) scan
- Transplants, including transplant evaluations
- Treatments provided as a part of **clinical trials**

Physical health services that do not require prior authorization

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

The following services will not require **prior authorization**:

- 48-hour observation stays (except for maternity delivery and cesarean section surgery— **physician** notification is required)
- Dialysis
- Electrocardiograms (EKGs)
- **Emergency** care (**in-network** and **out-of-network**)
- Family planning services
- Low-level plain film X-rays
- Postoperative pain management (must have a surgical procedure on the same date of service)

- Pediatric routine vision services
- Women's health care by **network providers** (OB/GYN services)

Behavioral health services requiring prior authorization

- All out-of-network services except **emergency** care
- Ambulatory detoxification
- Electroconvulsive therapy (ECT)
- Mobile crisis management
- Nonhospital medical detoxification
- Intensive outpatient treatment for opioid substance use treatment
- **Partial hospitalization**
- Professional treatment services in facility-based crisis programs (following the initial seven days/112 units)
- Psychiatric inpatient hospitalization
- Psychological testing

Behavioral health services that do not require prior authorization

- Diagnostic assessment
- Medication-assisted treatment (MAT)
- Mental health or substance dependence assessment
- Psychiatric and substance use disorder outpatient and medication management services
- Psychological testing

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 use documented **clinical review criteria** based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy. We obtain all information needed 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:

- Routinely assess the effectiveness and efficiency of our **utilization review** program.

- 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.
- Provide **covered persons** and their **providers** with access to our review staff via a toll-free phone number or collect call whenever any **provider** is required to be available to provide services that may require prior certification or authorization to any plan member. The department's clinical staff and medical directors are available and accessible to all **providers** and **members** from 8:00 a.m. to 5:00 p.m., Monday through Friday, with the exception of company observed holidays by calling our toll free number at 1-833-301-3377. Utilization Management clinical staff are available on call after normal business hours, weekend and holidays by calling 1-833-533-8686. A toll free fax line is available to receive inbound communications from **providers** 24 hours a day 7 days a week at 1-855-329-3377. TTD/TTY and language assistance is also available at 711.
- Limit our requests for information to only that information needed to certify or authorize the admission, procedure, or treatment; length of stay; and frequency and duration of **health care services**.
- Provide written procedures for making **utilization review** decisions and notifying **covered persons** of those decisions.
- 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. Within the following time frames, we will communicate our review determination, whether adverse or not, to your **provider** after we obtain all necessary information about the admission, procedure, or health care service, being requested also including but not limited to: clinical notes, clinical evaluations, and **second opinions** from a different clinician.

- Concurrent requests are decided and communicated within 24 hours from the date of receipt.
- Urgent care prospective requests are decided and communicated as soon as possible taking into account medical needs, but will not exceed 72 hours from the date of receipt.
    - A prospective request is considered urgent if it is determined that a 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 or in the opinion of a **physician** with knowledge of the **member's** medical condition, would subject the **member** to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

- From the date of receipt, non-urgent care prospective requests are decided and communicated within 5 calendar days if received electronically and within 8 business days if received from a non-electronic source.
- Retrospective requests are decided and communicated within 30 calendar days from the date of receipt.

Notification of utilization management decisions will be consistent with Delaware law and our policies. We may request additional information needed in making a decision from you or your **provider.** We will allow the following extension of the above time frames for you or your **provider** to submit this additional information based on the type of request:

- 45 calendar days for retrospective requests.
- 45 calendar days for non-urgent care prospective requests.
- 72 hours for concurrent requests.
- 48 hours for urgent care prospective requests.

If a **provider** or **member** fails to release necessary information in a timely manner, we may deny certification of the requested service. The determination to deny certification or authorization may be appealed.

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 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.
- A member can ask to extend the course of treatment beyond the prescribed time or number of treatments. In certain situations, we will make a benefit determination as soon as possible. This is the case when delay in the decision could reasonably appear to:
    - Seriously jeopardize the life or health of the **member**
    - Seriously jeopardize the **member's** ability to regain maximum function,
    - In the opinion of a **physician** with knowledge of the **member's** medical condition, would subject the **member** to severe pain that cannot be adequately managed without the care or treatment that the **member** is requesting.

  In making a decision, we will take any urgent medical needs into account. For concurrent and prospective requests received by the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, we will notify the **member** of the benefit determination, whether adverse or not, within 24 hours for concurrent requests

and within 72 hours for prospective requests after the plan's receipt of the request. 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 or authorize a health care service, we will notify the **member** and the **member's provider**. For an **adverse benefit determination**, we will notify the **member's provider** and send written or electronic confirmation of the **adverse benefit determination** to the **member**. For concurrent reviews, we will be responsible for **health care services** until the **member** has been notified of the **adverse benefit determination** (i.e., decertification does not become effective until notice is provided to the **covered person**). For retrospective reviews, 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** after the determination is made. We remain responsible for **health care services** until you have been notified of the **adverse benefit determination**. We will notify you orally or in writing.

To obtain **prior authorization** or verify requirements for inpatient or outpatient services, including which other types of facility admissions need **prior authorization**, you or your **provider** can call us at 1-833-301-3377.

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 **copayment**. Our contract with **network providers** for **covered health 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 **Schedule of Benefits**.

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

Covered Health Services

This section describes the services for which coverage is available when **medically necessary**. Please refer to the **Schedule 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 (**out-of-pocket maximum** amount).

The **Schedule of Benefits** and other **policy** documents are available on request by contacting our Member Services Department at 1-833-590-3300, 8 a.m. – 8 p.m., 5 days a week. You may also access **policy** documents online at www.amerihealthcaritasnext.com/de.

Please refer to the How To Use Your Health Plan section of this document to see whether services may require **prior authorization**.

Abortion services

We will only cover abortion services in cases of rape, incest, or when the mother's life is in danger.

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 that 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 an **in-network provider** in an office visit setting.

Ambulance services

We cover ambulance services (including volunteer services) by ground, air, or water for an **emergency**. Services must be provided by a licensed ambulance (including volunteer) service **provider** and 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 acute facility to a subacute facility or setting
- From an **out-of-network hospital** or facility to an **in-network hospital** or facility
- To a **hospital** that provides a higher level of care than was available at the original **hospital**

or facility

- To a more cost-effective acute care facility

If an out-of-**network** air ambulance transports you, they are prohibited from billing you for more than your **in-network** cost-share. Nonemergency air transportation requires **prior authorization**.

Autism spectrum disorders (ASDs)

We will cover the assessment, screening, diagnosis, and treatment of **autism spectrum disorders** for covered individuals younger than 21 years of age. **Covered health services** include:

- 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**.
- Evaluation and assessment services.
- **Habilitative or rehabilitation services**, including, but not limited to, occupational therapy, physical therapy, or speech and language therapy, or any combination of those therapies.
- Pharmacy services and medication as covered under the terms of this **policy**.
- Psychiatric care.
- Psychological care, including family counseling.
- Therapeutic care, which includes behavioral analysis and **habilitative** or **rehabilitation services.**

Certain services for ASD require **prior authorization**.

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.

Baseline lead poisoning screening or testing

We will cover baseline lead poisoning screening and testing. For children who are at high risk for lead poisoning under the guidelines and criteria established by the Division of Public Health, we will cover lead poisoning screening, testing, diagnostic evaluations, screening and testing supplies, and home-visits.

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 **prior authorization**.

Cancer monitoring test

We cover CA-125 monitoring of ovarian cancer subsequent to treatment.

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**.

Chiropractic Care

We will cover chiropractic services when performed and determined to be medically necessary by a network licensed chiropractor for the treatment or diagnosis of spinal conditions and neuromusculoskeletal disorders on an outpatient basis. **Covered health services** include initial office visit, chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function, ultrasound, traction therapy, and electrotherapy. Chiropractic x-rays are covered only for x-rays of the spine. Chiropractic services must either provide significant improvement in your condition in a reasonable and predictable period of time or be necessary to the establishment of an effective maintenance program.

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

- Chiropractic services that are a part of a maintenance program.
- Charges for care not provided in an office setting.
- Infusion therapy or chelation therapy.
- 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.
- Manipulation under anesthesia.
- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law.
- Vitamin or supplement therapy.

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

Clinical Trials

We will cover routine patient care costs for **covered persons** engaging in approved **clinical trials** for the treatment of life-threatening diseases. Benefits will be paid at the same level as other routine care services outlined in your **Schedule of Benefits.**

Any clinical trial receiving coverage for routine costs must meet the following requirements:

- The subject or purpose of the trial must be the evaluation of an item or service that falls within the covered benefits of the policy and is not specifically excluded from coverage.
- The trial must not be designed exclusively to test toxicity or disease pathophysiology.
- The trial must have therapeutic intent
- Trials of therapeutic interventions must enroll patients with diagnosed disease.
- The principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes.
- The trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
- The trial does not unjustifiably duplicate existing studies.
- The trial is in compliance with federal regulations relating to the protection of human subjects.

See the definitions section of this **Evidence of Coverage** for additional information on **clinical trials** and **routine patient care for clinical trials**.

Complications of pregnancy

We cover **medically necessary** services and supplies for treatment of complications of pregnancy. Complications of **pregnancy** will be treated the same as any other illness. A non-elective cesarean section is considered a **complication of pregnancy**. **Complications of pregnancy** will not be treated differently than any other illness or **sickness**.

Congenital cleft lip and palate care and treatment

We will cover **medically necessary** care and treatment including, but not limited to:

- Medical and nutritional services, 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
- Physical and speech and language 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.

Dental services for children with severe disabilities

We will cover hospital and anesthesia charges for dental procedures for **members** less than age 21, who due to a significant mental or physical condition, illness, or disease are likely to require specialized treatment or additional support to secure effective dental care. We will also cover accident-related dental services as outlined in the accident-related dental services section of this **policy**. If services are rendered by an **out-of-network provider**, payment shall be provided to the **out-of-network provider** at our reasonable and customary reimbursement rates for the same or similar services in the same geographical area. The **out-of-network provider** cannot balance bill you for costs beyond these reasonable and customary rates.

Developmental delay screening for infants and toddlers

We cover developmental screenings performed by a **network provider** for infants and toddlers at ages 9 months, 18 months, and 30 months.

Diabetes services and supplies

We cover the following **medically necessary** services and supplies for the treatment of diabetes when recommended in writing or prescribed by a **network physician**:

- Monitoring equipment, blood glucose meters and strips, urine testing strips, insulin, syringes and pharmacological agents for controlling blood sugar, and certain supplies that may be covered under your pharmacy benefit.
- Exams, including diabetic eye examinations and foot examinations.
- **Insulin pumps** and supplies needed for the **insulin pumps. Insulin pumps** are covered at no charge.
- Outpatient medical nutrition therapy services ordered by a physician and provided by appropriately licensed or registered health care professionals.
- Podiatric appliances for the prevention of complications associated with diabetes.
- Routine foot care.

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.

Durable medical equipment (DME) and Devices

We cover **medically necessary DME** ordered or provided by a physician. **DME** may require a **prior authorization**, 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. Prosthetic and orthotic devices are only covered if they are **provided** by a network vendor, and orthotic or prosthetic services are rendered by a network **provider**, who is licensed by the State to provide **prosthetics and orthotics**. **Prosthetics and orthotics** device coverage is limited to the most appropriate model that adequately meets the medical needs of the **covered person**. The repair and replacement of prosthetic and orthotic devices is covered unless necessitated by misuse or loss. **Medical formula or food** and **low protein modified food products** are covered for you and any family **members** covered under this **policy** if prescribed as **medically necessary** for the therapeutic treatment of **inherited metabolic diseases** and are administered under the direction of a **network** physician.

Emergency services

We will cover services needed to start 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 **in-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** and some post-stabilization services received from an **out-of-network provider** will be covered at the **in-network** benefit level. The **out-of-network provider** is prohibited from billing you more than your **in-network** cost-share.

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).

Your **plan** provides coverage for the following contraceptive methods at no cost**:**

- Food and Drug Administration (FDA) approved contraceptive drugs, devices and products.

  If the FDA has approved 1 or more **therapeutic equivalents** of a contraceptive drug, device, or product, your **plan** will cover at least 1 of these **therapeutic equivalents** at no cost to you. You may be required to pay a cost-share for other **therapeutic equivalents** unless your **network provider** determines a particular FDA approved contraceptive is **medically necessary**.

- FDA approved **emergency** contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of state law.

- A prescription for contraceptives intended to last for no more than a 12-month period which may be dispensed all at once or over the course of the 12-month period.
- Voluntary female sterilization procedures.
- Education and counseling on contraception.
- Follow-up services related to covered contraceptive drugs, devices, products, including management of side effects, counseling for continued adherence, and device insertion and removal.
- Immediate postpartum insertion of long-acting reversible contraception

Certain contraceptive medications may be covered under your pharmacy benefit.

The following services are excluded from coverage under your **policy** and will not be covered:

- Abortion, unless the abortion is necessary to save the life or health of the member, or as a result of incest or rape
- Fetal reduction surgery
- Reversal of sterilization or vasectomies
- Services related to surrogate parenting

Fertility care and infertility services

We will cover services for the diagnosis, treatment, and correction of any underlying causes of **infertility** when determined to be **medically necessary** by a **network provider**. This includes coverage of certain prescription drugs, in vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and **standard fertility preservation services** for **covered persons** who must undergo **medically necessary** treatment that may cause **iatrogenic infertility**. The following are additional services covered under your fertility care and **infertility** benefit:

- Assisted hatching.
- Cryopreservation and thawing of eggs, sperm, and embryos.
- Cryopreservation of ovarian tissue.
- Cryopreservation of testicular tissue.
- Embryo biopsy.
- Consultation and diagnostic testing.
- Fresh and frozen embryo transfers.
- Intrauterine insemination.

- In vitro fertilization (IVF), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate.
- Intra-cytoplasmic sperm injection (ICSI).
- Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with a **covered person's** religious or ethical beliefs.
- Medications.
- Ovulation induction.
- Six completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (SET) when recommended and medically appropriate.
- Storage of oocytes, sperm, embryos, and tissue.
- Surgery, including microsurgical sperm aspiration.

In order to obtain coverage for fertility care and **infertility** services all of the following requirements must be met:

- A board-certified or board-eligible obstetrician-gynecologist, subspecialist in reproductive endocrinology, oncologist, urologist, or andrologist verifies that the **covered person** is diagnosed with **infertility** or is at risk of **iatrogenic infertility**.
- The **covered person** must not have been able to obtain a successful pregnancy through reasonable effort with less costly **infertility** treatments covered by this **policy**:
    - No more than 3 treatment cycles of ovulation induction or intrauterine inseminations will be required before IVF services are covered.
    - If IVF is determined by your **network provider** to be **medically necessary**, no cycles of ovulation induction or intrauterine inseminations will be required before IVF services are covered.
    - IVF procedure must be performed at a practice that conforms to American Society for Reproductive Medicine and American Congress of Obstetricians and Gynecologists guidelines.
- For IVF services, retrievals must be completed before the **covered person** is 45 years old and transfers must be completed before the **covered person** is 50 years old.

This benefit is limited to 6 completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (SET) when recommended and medically appropriate.

Habilitative services

Medically necessary services for habilitation, including speech therapy, occupational therapy, and physical therapy must be ordered by a **physician** and delivered by appropriately licensed medical personnel. Services must be provided to help a person keep, learn, or improve skills and functioning of daily living. We will determine if the service is covered by reviewing both the skilled nature of the service and the need for **physician** management. These services may be provided in an inpatient or outpatient setting.

Covered health services also include therapy for a child who is not walking or talking at the expected age, services provided for people with disabilities in a variety of inpatient and/or outpatient settings, chiropractic manipulative treatment with or without ancillary physiologic treatment and/or **rehabilitative** methods rendered to restore/improve motion, reduce pain, and improve function. This applies 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:

- Charges for care not provided in an office setting
- Chelation therapy
- 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
- Manipulation under anesthesia
- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law
- Vitamin or supplement therapy

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

Hearing aids and hearing services

Your coverage allows for one **hearing aid** per hearing impaired ear, once every 36 months. **Hearing aids** and hearing services are subject to **prior authorization**. Hearing services include:

- Cochlear and auditory brainstem implant external parts replacement and repair.
- Cochlear and auditory brainstem implants.
- Implantable bone conduction **hearing aids** (bone-anchored **hearing aid** BAHA).
- Soft band and implantable bone conduction **hearing aid** external parts replacement and repair.
- Audiological office visits to examine and assess the **member's hearing aid** device and hearing service needs.

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. Home health services are limited to one visit per day, per specialty. A nurse and a **home health aide** count as one specialty for this benefit. Please refer to your **Schedule 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 the 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 cannot 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.

Lymphedema services

We will cover services related to the diagnosis, evaluation, and treatment of lymphedema. This coverage includes **medically necessary** equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education.

Mastectomy and breast cancer reconstruction

Benefits are provided for mastectomy and breast reconstruction performed in an inpatient or outpatient setting for the following when determined to be **medically necessary** by the **member's** attending physician subject to the approval of AmeriHealth Caritas Next:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the non-diseased other breast to produce symmetrical appearance.

Prostheses and treatment of physical complications of all stages of mastectomy, including

lymphedemas. 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.

Breast reconstruction is covered regardless of the time elapsed between the mastectomy and the reconstruction. These **benefits** will be provided subject to the same **deductible** 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.

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:

- Day treatment programs.
- Diagnostic testing to evaluate a mental condition.
- Intensive Outpatient Programs.
- Outpatient office visits.
- Outpatient psychological tests (limit of 8 hours of tests per year).
- Outpatient **rehabilitation services** in individual or group settings.
- Short-term **partial hospitalization**.

Mental health and substance use services are excluded and not covered by your **health benefit plan** when related to:

- Court-ordered services required for parole or probation.
- Marital and relationship counseling.
- Testing for aptitude or intelligence.
- Testing for evaluation and diagnosis of learning abilities.

AmeriHealth Caritas Next complies with the federal Mental Health Parity and Addiction Equity Act. We provide coverage for mental health and substance use services in parity with medical

or surgical **benefits** within the same classification or subclassification.

Other practitioners/provider office visits

We will cover primary and specialty care office visits for the treatment of illness or injury with qualifying **providers** who are practitioners other than a **physician**, such as physician assistants or nurse practitioners.

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 autoimmune neuropsychiatric disorders

We cover services and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

Pediatric Vision services

We cover pediatric **vision services** through the last day of the month in which a child turns age 19. **Covered health 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 **Schedule 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 health 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, not including the day of delivery or surgery. You are not required to obtain **prior authorization** during this time frame, however, **prior authorization** is required after the minimum duration inpatient stay expires. The mother could be discharged earlier. If so, timely post-delivery follow-up care will be provided to the mother no later than 72 hours immediately following discharge.

Complications of pregnancy are treated the same as any other illness. An **emergency** (non-elective) cesarean section is considered a **complication of pregnancy**.

Coverage also includes well-baby care and hearing loss screening tests of newborns and infants in the **hospital** or birthing center. Complications of pregnancy are treated the same as any other illness. An **emergency** (non-elective) 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 fill your prescription medications from a **network pharmacy** for it to be covered under your prescription drug benefit. 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.

We will cover benefits for any outpatient drug prescribed by a **network provider** to treat a **covered person** for a covered chronic, disabling or life-threatening illness if the drug:

- Has been approved by the FDA for at least 1 indication; and
- Is recognized for treatment of the indication for which the drug is prescribed in:
  - A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or
  - Substantially accepted peer reviewed medical literature.

Coverage includes **medically necessary** services associated with administration of the drug, however, does not include coverage for:

- Medication that may be obtained without a physician’s prescription;
- Experimental drugs not otherwise approved for the proposed use or indication by the Food and Drug Administration; or
- Any disease, condition, service or treatment that is excluded from coverage under the **policy**.

Your **health benefit plan** covers **prescription insulin drugs** and will include at least one formulation of each of the following types of **prescription insulin drugs** on the lowest tier of the drug **formulary** developed and maintained by your **health benefit plan.**

- Rapid-acting
- Short-acting
- Intermediate-acting
- Long-acting

Your cost-share responsibility for insulin prescription drugs will be no more than $100 per month for each enrolled individual, regardless of the amount or types of insulin needed to fill the covered individual's prescription. This $100 capitation includes **deductible** and **cost-sharing** amounts once **deductible** is met.

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 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 switch to another covered medication if you are on a long-term prescription. The **formulary** listing is available on request by contacting our Member Services at 1-833-590-3300, 8 a.m. – 8 p.m., 5 days a week. A searchable **formulary** is available at https://www.amerihealthcaritasnext.com/de/view-plans/searchable-drug-list.aspxlist.aspx. You can enter a medication name to see if it is covered on the **formulary**, what drug benefit tier it is on, and if there are any limitations such as **Prior Authorization**, **Step Therapy**, **Quantity Limits** or Age Limits. There is also a printable **formulary** document at https://www.amerihealthcaritasnext.com/de/view-plans/searchable-drug-list.aspx which. It shows all of the medications on the **formulary**, their drug benefit tiers and any limitations.

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

Your pharmacy **formulary** is a closed **formulary**. This means products not listed on the **formulary** are treated as non-formulary and will not be covered by your **health benefit plan**. It is possible that there is a prescription drug you are currently taking, or one that you and your prescribing **provider** think you should be taking, that is not on the **formulary** list. Drugs not on the **formulary,** including drugs that have not been reviewed for inclusion in the **formulary**, can still be requested. Our PBM's coverage determination and **prior authorization** process allows the opportunity for non-formulary exceptions.

To make a request for coverage of a non-formulary drug, you, your authorized representative, or prescribing **provider** may call us at phone number 1-833-733-7977 or you may fill out the online submission form at https://ppa.performrx.com/PublicUser/OnlineForm/OnlineFDBSingleForm.aspx?cucu_id=Y65L6nti7Fh2jJt8A7Rsjw%3d%3d. Requests can also be sent via fax to 1-833-981-7979 or by mail at PerformRx/AmeriHealth Caritas Next, PO Box 516, Essington, PA 19029. If submitting a request by mail or by fax we recommend you view the online submission form or contact us by phone to ensure all applicable and necessary information is included in your request.

Once the request is received, our PBM will review the request for **medical necessity** and appropriateness. For a standard exception review, we will make our decision no later than 72 hours of the date we received the request and any additional required information. You can request an expedited (fast) exception if you, your authorized representative, or prescribing **provider** believe that your health could be seriously harmed by waiting up to 72 hours for a decision. You can indicate your urgent circumstance on your request by asking for an expedited review. We will give you a decision on expedited requests no later than 24 hours after we receive the request and any additional required information.

If the non-formulary request is denied and you feel we have denied the request incorrectly, you may challenge the decision through our internal dispute process. If a determination is made to uphold the original denial decision through our internal dispute process, then on exhaustion of that process, you have the right to ask for either a standard or, if warranted and appropriate, an expedited external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). Your denial notice will explain your right to external review and provide instructions on how to make this request. An external review request can be made by you, your authorized representative, or your prescribing **provider**

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 an **in-network provider**. Services which are ordered by a **network provider** to diagnose or treat a medical condition are not considered a preventive care service. Services received are billed at the appropriate cost-share described in your **Schedule of Benefits**.

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

- Abdominal aortic aneurysm screening for men ages 65 – 75 who have ever smoked
- Cervical cancer screening — examination and laboratory tests for early detection and screening including Pap smear, liquid-based cytology, and human papillomavirus detection. We will cover 1 annual pap smear for females age 18 and over
- Colorectal cancer screening — Colorectal cancer screenings are covered for **covered persons** who are 50 years of age or older or if a **covered person** is deemed at high risk for colon cancer for any of the following reasons:
    - **Covered person** has a background, ethnicity, or lifestyle such that the treating **provider** believes the **covered person** is at an elevated risk for colon cancer
    - **Covered person** has chronic inflammatory bowel disease
    - **Covered person** has a family history of breast, ovarian, endometrial or colon cancer or polyps

- **Covered person** has a family history of familial adenomatous polyposis
- **Covered person** has a family history of hereditary nonpolyposis colon cancer

Colorectal cancer screenings are covered as determined by the Secretary of Health and Human Services of this State after consideration of recommendations of Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories, and frequencies referenced in such recommendations and deemed appropriate by the attending physician.

Colorectal cancer screening **covered health services** include:

- A colonoscopy every ten years
- An annual fecal occult blood test
- A flexible sigmoidoscopy every five years
- A screening barium enema or test consistent with approved medical standard and practice to detect colon cancer every five years
- In appropriate circumstances radiologic imaging or other screening modalities **Covered health services** include the use of anesthetic agents (if the use of such anesthetic agents is determined to be **medically necessary** by your **provider)** including general anesthesia in connection with colonoscopies and endoscopies performed in accordance with generally accepted standards of medical practice and all applicable patient safety laws and regulations.

- Mammograms/OBGYN — in accordance with the most recent guidelines of the American Cancer Society, we cover one baseline mammogram for any female **member** ages 35 – 39, one mammogram per female **member** every two years beginning at age 40, and one mammogram per female **member** per **benefit period** beginning at age 50
- Newborn hearing screening
- Nutritional counseling
- Ovarian cancer screening — for female **members** age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered
- 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
- Prostate cancer examinations, screenings, and laboratory work for diagnostic purposes per the most recent published guidelines of the American Cancer Society
- 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

The complete list of federally required preventive services can be found at the federal Health Insurance Marketplace website at:

https://www.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. **Chronic care management services** are covered at no charge to the **member** and is not subject to any **deductibles**.

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. Private duty nursing care is covered when you are an inpatient in an acute hospital. Services are limited to 240 hours per benefit year.

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**. Radiation therapy is covered for cancer and neoplastic diseases.

Rehabilitation services

Medically necessary services for **rehabilitation**, including cardiac rehabilitation and pulmonary rehabilitation, speech therapy, 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.

Outpatient **rehabilitation services** are only covered when the service can help your condition improve in a reasonable and predictable amount of time, or is needed to establish an effective home exercise program. In order for speech therapy services to be covered the service must be

determined **medically necessary** to improve speech problems caused by disease, trauma, congenital defect, or recent surgery. .

Some **rehabilitation services** have benefit limitations:

- Occupational and physical therapy services are limited to a total of 30 visits per **benefit period** regardless of which benefit category the service falls under.
- Speech therapy services are limited to a total of 30 visits per **benefit period** regardless of what benefit category it falls under.
- Cardiac rehabilitation is limited to 3 sessions per week and 12 weeks of treatment. Additional services are available if determined to be **medically necessary** by your network physician and you receive medical review and approval by us.

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

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.

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:

- **Covered health services** do not include custodial, domiciliary care, or long-term care admissions.
- **Covered health services** must be of a temporary nature and must be supported by a treatment plan.
- The admission is ordered by the **covered person's** attending physician. We require written confirmation from the physician that skilled care is necessary.
- The **skilled nursing facility** is a **Network Provider.** Coverage is limited to 120 days per confinement. A confinement includes all admissions not separated by 180 days.

Specialist visits

Office visits for specialty care services are covered.

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. **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.

Temporomandibular joint (TMJ) disorder

Treatment is covered if there is documented organic joint disease, or joint damage resulting from physical trauma.

Transplant services

We will cover organ and tissue transplants when ordered by a physician, approved through **prior authorization**, 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. When the recipient is a **member** under this **policy**, both the recipient and the donor are entitled to **covered health services**, including services reasonably related to the organ removal. 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.

Your health benefit plan has a maximum benefit limit per transplant of $10,000 for each cadaveric organ and up to $45,000 for each organ procured from a living donor including organ harvesting. Kidney and bone marrow transplants do not apply to this limit. For kidney transplants, if there is not a network transplant facility available living donor costs are limited to $50,000 not including harvesting.

Urgent care services

Covered health services include **medically necessary** services by a **network provider**, including approved 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 **in-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** unless you receive prior authorization for **out-of-network** services. In order for a benefit to be paid the **covered health services** must 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**.

This **health benefit plan** does not cover the following:

- Any care which extends beyond traditional medical management or **medically necessary** inpatient confinements for conditions such as learning disabilities, behavioral problems, or intellectual disabilities. Examples of care which extends beyond medical management include, but are not limited to, the following:
    - Educational services such as remedial education including tutorial services or academic skills training
    - Neuropsychological testing including educational testing such as I.Q. tests, mental ability, and aptitude tests unless these tests are for an evaluation related to medical treatment
    - Services to treat learning disabilities, behavioral problems, or intellectual disabilities
- 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. This exclusion does not apply to **National Coverage Determination Services**
- Any items or services related to personal hygiene or convenience whether or not they are specifically recommended by a **network provider** or **out-of-network provider,** such as air conditions, humidifiers, physical fitness equipment, stair glides, elevators/lifts or barrier free home modifications
- Any medical and/or recreational use of cannabis or marijuana
- Any prescription or over-the-counter drugs not on the **formulary** unless an exception is granted
- Any prescription vitamins, except vitamins prescribed during **pregnancy**, and fluoride vitamins, or as indicated as covered in the **formulary**
- Any rehabilitative occupational and physical therapy services which are not intended to improve your condition in a reasonable and predictable amount of time
- 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**
- Biofeedback

- Care given by a family member or person living with you

- Diabetes education services
- Diabetes prevention programs offered by **out-of-network providers**
- Diagnosis and treatment of jaw joint problems unless specifically covered under this **policy,** including but not limited to:
    - Crowns or bridges
    - Dental implants or root canals
    - Extractions
    - Orthodontic braces
    - Occlusal (bite adjustments)
    - Treatment of periodontal disease
    - Treatment of **temporomandibular joint disorders** unless for treatment of a documented organic joint disease or joint damage resulting from physical trauma
- Expenses, fees, taxes, or surcharges imposed by a **provider** or facility that are actually the responsibility of the **provider** or facility
- For inpatient admissions which are primarily for physical medicine or for diagnostic studies unless determined to be medically necessary by your treating **provider**.
- For treatment of **sexual dysfunction** not related to organic disease or injury
- Habilitation speech therapy services for treatment of attention disorders, behavior problems, conceptual handicaps, learning disabilities, and developmental delays
- **Hearing aids** for **member's** over the age of 23
- Male condoms
- Prescription drugs and services to decrease weight loss including weight reduction programs
- Private duty nursing services provided in special care units of the **hospital**. This includes private duty nursing services provided in self-care units, selective care units, and intensive care units.
- Services provided in conjunction with a non-covered service.
- The following are not covered for at-home treatment or care under this **policy's home health care** benefit:
    - Care not prescribed in the approved treatment plan

  - Chemotherapy and radiation therapy
  - Chronic condition care
  - Dietary care
  - Disposable supplies
  - **Durable medical equipment**
  - Homemaker services such as housekeeping and cooking
  - Imaging services
  - Inhalation therapy
  - Laboratory tests
  - Prescription drugs except home infusion services
  - Volunteer care
- The following are not covered under this **policy's hospice** benefit:
  - Care not prescribed in the approved treatment plan
  - Financial, legal, or estate planning
  - Homemaker services such as housekeeping, food and meal preparation, and cooking
  - **Hospice** care in an acute care facility unless the **member** receiving **hospice** care requires services in an inpatient setting for a limited amount of time not prescribed as a part of an approved treatment plan.
  - Private duty nursing
  - Respite care
- The following **skilled nursing facility** services are not covered under your policy:
  - Convalescent care
  - Custodial care
  - Domiciliary care
  - Intermediate, rest, or homelike care
  - Long-term care admissions
  - Protective and supportive care
- Services provided by a naturopathic **physician**
- Tinnitus maskers
- Treatment received outside the United States, except for a medical **emergency** while

traveling in accordance with the **emergency services** section of this **policy**

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

- Abortions, except in the case of rape, incest, or danger to the mother
- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form
- Any examinations, tests, screenings or any other services required by:
    - For employment or government-related diagnostic testing, laboratory procedures, screenings, or examinations
    - A university, school, or college in order to enter school property or a particular location regardless of reason
    - A governmental body for public surveillance purposes
- Care needed through service in the armed forces of any country.
- For **behavioral health** and **substance use disorder** services related to:
    - Court-ordered services required for parole or probation
    - Marital and relationship counseling
    - Testing for aptitude or intelligence
    - Testing for evaluation and diagnosis of learning abilities
- 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 dental services. We will inform **members** of the availabilities of stand-alone pediatric dental plans during the plan selection and enrollment process
- For expenses related to television, phone, or expenses for other persons
- For fetal reduction surgery
- 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 routine or periodic physical examinations, except as otherwise set forth in this **policy**; the completion of forms or the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for employment, school, camp, travel or sports, except as mandated by Delaware law

- For services required as a result of a court order or other tribunal unless determined to be **medically necessary** by your **network physician** or coverage is required by federal or Delaware state law
- For services related to surrogate parenting
- For standby availability of a medical **provider** when no treatment is rendered
- For the reversal of sterilization or vasectomies
- 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
- Immunization services required for foreign travel or employment purposes
- 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**

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 a **grievance** or **appeals**. You have the right to file a **grievance**, file an **appeal**, and right to an external review with respect to certain **Adverse Benefit Determinations** or **appeals** not decided in your favor.

When AmeriHealth Caritas Next receives an initial **complaint**, we will respond within a reasonable amount of time after submission. At the time of initial receipt of your **complaint,** we will inform you of your right to file a **grievance** at any time and help you do so.

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. Concerns related to the denial of a claim or request for service are considered **appeals**. Our **grievance** process is available for review of any **policy**, decision, or action we make that affects the **member**.

If you need help with filing a **grievance** or **appeal**, we will help walk you through the process. This includes help with completing forms, providing interpreter and translation services, or providing TTY support and ancillary aid. Additionally, free letter translations are available on request. This service is provided to you at no charge by contacting our Member Services at 1-833-613-2262 (TTY 711).

Grievances

You, your authorized representative, or your **provider** can file a **grievance** with us at any time. You can do so in writing or over the phone. **Grievances** must be submitted within one year after the date of occurrence of the action that initiated the **grievance**. The **grievance** process is voluntary.

A **grievance** should be provided to us by you or your authorized representative by phone at 1-833-590-3300 or in writing at:

Member Grievances

AmeriHealth Caritas Next

PO BOX 7430

London, KY 40742-7430

On 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**.

Once we have received your **grievance**, we will send you written acknowledgement of receipt within 5 business days of receiving it. A **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 have:

- 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.
- A reference to any documentation used as a basis for the decision.

The Delaware Department of Insurance is available to help insurance consumers with insurance related problems and questions. You may ask by phone at 1-800-282-8611.

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 1-833-590-3300.

Expedited grievance

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.

Standard appeals

You or your authorized representative can file an **appeal** of an **Adverse Benefit Determination** verbally by calling Member Services at 1-833-590-3300 or in writing to AmeriHealth Caritas Next, P.O. Box 7135, London, KY 40742-7135. 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 authorized representative. We will also help you with filing the written **appeal** if you need it.

Verbal **appeals**: The date you make your verbal **appeal** counts as the date of receipt of your **appeal**. We will send you written notice acknowledging receipt of your verbal **appeal** within five calendar days.

Once your appeal request is received, we will begin researching your **appeal**. Within five 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 we have that relate to the subject of the **appeal** at no cost to you. You can ask for these records and documents by calling our Member Services at 1-833-590-3300, 8 a.m. – 8 p.m., 5 days a week. If your review required **physician** review, the physician reviewing your **appeal** will:

- Not have been involved in the previous decision on your claim or request for service
- Have the appropriate training in your condition or disease
- Not be a subordinate of any person involved in the initial decision to deny services

You can provide evidence to support 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 **appeal**ed either until the end of the approved treatment period or the determination of the **appeal**.

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 1-833-590-3300 (TTY 711). 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 either verbally or in writing. You can file a request for an expedited **appeal** with our Member Services department by phone at 1-833-590-3300 or in writing at AmeriHealth Caritas Next, P.O. Box 7135, London, KY 40742-7135. 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 or in the opinion of a **physician** with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Your **provider** can also file a verbal request for an expedited **appeal**. We will not require written follow-up for a verbal request for an expedited **appeal**. We may require documentation of the medical justification for an expedited **appeal**.

We will assign your request for an expedited **appeal** to a **clinical peer**. 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 notify you verbally of our decision within 72 hours of receiving the expedited **appeal** 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**. You have the right to submit a **grievance** if the expedited **appeal** request is handled as a standard **appeal**.

We will, in consultation with a doctor provide expedited review and communicate the decision to covered **members** and their **providers** as soon as possible, but not later than 72 hours 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 **Adverse Benefit Determinations**.

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 expedited **appeal** will:

- Not have been involved in the previous decision on your claim or request for service.
- Have the appropriate training in your condition or disease.
- Not be a subordinate of any person involved in the initial decision to deny services.

Independent external review procedure

Delaware law makes available to you an independent external review of **Adverse Benefit Determination** decisions made by AmeriHealth Caritas Next. The external review will be performed by a third party independent review organization (IRO) who is not associated with AmeriHealth Caritas Next. This service is provided to you at no charge. External review is performed on a standard or expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. We will notify you in writing of your right to request an external review each time you:

- Receive an **Adverse Benefit Determination** decision.
- Receive an **appeal** decision upholding an **Adverse Benefit Determination** decision also known as a **Final Determination.**

When processing your request for external review, we will require you to provide 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.

If you have any questions or concerns regarding the independent external review process, please contact Member Services at 1-833-590-3300 (TTY 711).

You also may contact the Delaware Department of Insurance at 1-800-282-8611.

Exhaustion of internal appeals

A request for external review may not be made until the **covered person** has exhausted our internal **appeal** process. You will be considered to have exhausted the internal review process if:

- You completed our **appeal** process and received a **Final Determination** from us; or
- You received notification that we have agreed to waive the exhaustion requirement; or
- We did not issue a written decision within the time frames outlined in the expedited and

standard **appeals** section of this **policy** after receiving all information necessary to complete the a**ppeal** unless you or your authorized representative agreed to a delay; or

- You submit an expedited external review request at the same time as an expedited internal **appeal** with us.

Eligibility for independent external review

For your request to be eligible for external review:

- Your coverage with us must be in effect when the **Adverse Benefit Determination** decision was issued;
- The service for which the **Adverse Benefit Determination** was issued appears to be a covered service under your **policy**; and
- You have exhausted our internal review process as described below unless you submit an expedited external review request at the same time as an expedited internal **appeal** with us.
- Your request must be a consideration of whether AmeriHealth Caritas Next is complying with the surprise billing and **cost-sharing** protections under the Public Health Service Act or be a determination that resulted in an **Adverse Benefit Determination** decision for reasons of:
    - **Medical necessity**, appropriateness, health care setting, level of care or effectiveness of health services, or the treatment that you are requesting is **experimental** or **investigational**; or
    - A rescission in coverage.

If your request for a standard external review is related to a retrospective **Adverse Benefit Determination** (an **Adverse Benefit Determination** that 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 receive a written **Final Determination** notice. An expedited external review is not available for retrospective **Adverse Benefit Determinations**.

Standard external review requests

Your request for standard external review must be submitted in writing to AmeriHealth Caritas Next within four months of receiving our notice of **Final Determination** that the services in question are not approved. You can submit this request to us at the following address AmeriHealth Caritas Next, PO BOX 7432, London, KY 40742-7432 or fax the request to 1-844-486-3290.

Expedited external review requests

An expedited external review of an **Adverse Benefit Determination** decision may be available if:

- Your treating **physician** certifies that you have a serious 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; or

- Your request for external review concerns an admission, availability of care, continued stay, or health care service for which you received **emergency** care as defined by state law, but have not been discharged from the facility.

Expedited external review requests must be submitted within four months from the date on your **Final Determination** notice. You can submit your request either verbally by contacting Member Services at 1-833-590-3300 (TTY 711) or in writing at the following address AmeriHealth Caritas Next, PO BOX 7432, London, KY 40742-7432 or fax the request to 1-844-486-3290.

IRO external review eligibility determination

Within five business days of receipt of your request for a standard external review, we will complete a review of your request to determine if you meet the eligibility requirements for external review. If you do not meet the criteria for external review eligibility, we will notify you, your **provider**, or the authorized representative who submitted the request of our eligibility determination within one business day of our review decision. If a request is made for an expedited external review we will make a determination of whether your request meets expedited requirements in consultation with a medical professional. If your request is not accepted for expedited review, we may:

- Accept the case for standard external review if our internal **appeal** process was already completed, or
- Require the completion of our internal **appeal** process before you may make another request for an external review.

If you are dissatisfied with our decision you may contact the Delaware Department of Insurance for further assistance.

Expedited external review requests will be immediately sent to the Department of Insurance for IRO assignment not to exceed 3 business days from the date of receipt.

IRO assignment

If your request for external review is accepted, an IRO will be assigned on a rotating basis. We are required to submit all documents and any information considered in making the **Adverse Benefit Determination** or **Final Determination** to the IRO within seven days of the IRO's receipt of your request for standard external review and as expeditiously as possible for expedited external review requests. If we do not provide all pertinent information to the IRO within the time frame outlined above, it will not delay the conduct of your external review and the IRO may terminate the external review and make a decision to reverse the **Adverse Benefit Determination** or **Final Determination**. If this occurs the IRO will immediately contact us and you or your authorized representative.

For standard review requests, within five days from receipt of the request the IRO will provide written notice to the requestor of the request eligibility and acceptance for external review. The notice will include the right to submit additional information pertaining to the case. You or your authorized representative will have 7 days from the date of receipt of the notice to submit this additional information. Any additional information provided to the IRO will be shared with us so we may reconsider our initial decision. The external review will be terminated if we decide to reverse our decision and approve your request based on the information provided.

IRO review and decision

The IRO will communicate its determination within 45 calendar days for standard external review requests and within 72 hours for expedited external review request from the date they received the initial request. Standard external review requests determinations will be provided to the requestor in writing, however, expedited review request decisions can be communicated verbally or in writing. If the decision is communicated verbally the IRO will send written notice within 48 hours following verbal notification within the appropriate regulatory time frame.

If the IRO's decision is to reverse the **Adverse Benefit Determination**, we will reverse the **Adverse Benefit Determination** decision by approving the covered benefit or supply that was the subject of the **Adverse Benefit Determination**. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the **Adverse Benefit Determination**, we will only provide coverage for those services or supplies you actually received or would have received before **disenrollment** if the service had not been denied 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 **Adverse Benefit Determination** decision for which you have already received an external review decision.

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Claims and Reimbursement

Claims

AmeriHealth Caritas Next is not liable under this **policy** unless proper notice is furnished to us by you or someone authorized to act on your behalf that **covered health services** have been rendered to a **member**. Claims will be paid in accordance with Delaware Prompt Pay laws.

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. Claims will be paid in accordance with state law.

Out-of-network provider claims

In order for **out-of-network** services to be covered, **prior authorization** must be obtained prior to the service being rendered unless described elsewhere in this document. You 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 Next within 180 days of the date of service. Failure to submit a claim within this time 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. In no event, except in the absence of legal capacity of the **member**, may the claim be submitted later than one year from the time the claim submittal was originally required.

Notice of claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to AmeriHealth Caritas Next or our agent. Notice should include the name of the insured and the policy number.

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 health 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 health services** received per the provisions of this **policy**. If you need to make payment other than a required **copayment**, **deductible**, or **coinsurance** amount at the time **covered health 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 for filing a proof of loss or send you a claim form by mail if you request it. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving AmeriHealth Caritas a written statement of the nature and extent of the loss within the time limits stated in the Proofs of loss section.

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.

Proofs of loss

Written proof of loss must be given to AmeriHealth Caritas Next for which this **policy** provides any periodic payment contingent upon continuing loss within 90 days after the end of each period for which the AmeriHealth Caritas Next is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, AmeriHealth Caritas Next may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Time of payment of claims

Claim payments for **benefits** payable under this **policy** will be processed immediately upon receipt of a proper proof of loss.

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 **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 or covered by any note or written order 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 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** about 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 about our **member** rights and responsibilities policies by contacting Member Services.
- 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 per applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive **health care services** without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The plan will provide information concerning advance directives to **members** and **providers** and will support **members** through our medical record-keeping policies.
- Obtain a current directory of **network providers**, on 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 from the **health benefit plan** 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 help 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. This includes 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 medical 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, **Schedule of Benefits**, and attached papers, if any, constitutes the exclusive and entire contract of insurance between you and the health plan, and shall be binding on 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 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 Next, or the person designated by an officer of AmeriHealth Caritas Next. 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.

Time limits on certain defenses

After 2 years from the date of issue of this **policy**, no misstatements, except fraudulent misstatements, made by the applicant in the application for such **policy** shall be used to void the **policy** or deny a claim for loss incurred as disability (as defined in the **policy**) commencing after the expiration of such 2-year period. No claim for loss incurred as disability (as defined in the **policy**) commencing 2 years from the date of issue of this **policy** shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the **effective date** of coverage of this **policy**.

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 Delaware law or with any applicable federal law that imposes additional requirements beyond what is required under Delaware law will be amended to conform to the minimum requirements of such law.

Nondiscrimination

AmeriHealth Caritas VIP Next, Inc. does not discriminate on the basis of race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.

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/de/contact/index.aspx or call our Member Services team at 1-833-590-3300.

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**.

Legal Actions

No action at law or in equity shall be brought to recover on this **policy** prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this **policy**. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Change of beneficiary

Unless you make an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to AmeriHealth Caritas Next and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this **policy** or to any change of beneficiary or beneficiaries, or to any other changes in this **policy**.

Misstatement of age

If the age of the insured has been misstated, all amounts payable under this **policy** shall be such as the **premium** paid would have purchased at the correct age.

Physical examinations and autopsy

AmeriHealth Caritas Next at its own expense may have the insured examined as often as reasonably necessary while a claim is pending and in cases of death of the insured the AmeriHealth Caritas Next at its own expense also may have an autopsy performed during the period of contestability unless prohibited by law.

Coordination of Benefits

This **policy** does not coordinate **benefits** with any other policies. That means that this **policy** pays **benefits** regardless of other coverage you might have.

Subrogation

To the extent that **benefits** for **covered health services** are provided or paid under this **policy**, the plan shall be subrogated and succeed to any rights of recovery of a **member** as permitted by law for expenses incurred against any person, firm, corporation, business entity, or organization except **insurers** on policies or health insurance issued to and in the name of the **member**. The **member** shall execute and deliver such instruments and take such other reasonable action as the plan may require to secure such rights, as permitted by law. The **member** shall do nothing to prejudice the rights given the plan by this paragraph without its consent. These provisions shall not apply where subrogation is specifically prohibited by law.

Congenital defects and anomalies

AmeriHealth Caritas Next provides the same **benefits** for covered minor children with congenital defects or anomalies as any other sickness or illness the minor child may have.

HOW TO CONTACT US

Method	Member Services — contact information
Call	1-833-590-3300 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free.
Fax	1- 866-329-3367
Write	Mailing address: 200 Stevens Drive, Philadelphia PA 19113
Website	https://www.amerihealthcaritasnext.com/de/contact/index.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.
- Help 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:

تنبيه: إذا كنت تتحدث اللغة العربية، فيمكنك االستعانة بخدمات المساعدة اللغوية بدون مقابل. اتصل برقم خدمات أألعضاء المدون على

بطاقة التعريف الخاصة بك.

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:

ધ્યાન આપો: જો તમે અંગ્ેજી સિવયા્ની અન્ કોઇ ભયાષયા બોલો છો, તો તમયારયા મયાટે ભયાષયા िહયા્ ેવયાઓ સનઃશલ પર કોલ કરો. ક ઉપલબ્ધ છે. તમયારયા આઇડી કયાડ પર રહલ યા િદસ્ની ેવયાઓનયાં નબર

Hindi:

ध्यान दें: ्दद आप अंग्रेजी करे अलयावया कोई अन् भयाषया बोलतरे हैं, तो आपकरे ललए मुफ़्त में भयाषया सहयात्तया सरेवयाएं उपलब्ध हैं। आपकरे आईडी कयाड्ड पर ददए गए सदस् सरेवया नंबर पर कॉल करें।

Laotian:

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອ່ ນ , ການບໍ່ວິການຊ່ວຍເຫຼືອ ດ້ານພາສາທ່ ີບ່ ນ ອກຈ ກພ ສ ອ ກ

Mon-Khmer:

ចាប់អារម្មណ៍ ៖ បបសិនបបើបោកអ្នកនិយាយភាសាបប្បេង បបរៅពីភាសាអង់ប្លេស បោះបសវា ជំនួយភាសាបោយឥតគ្ិតថ្ល ីមានសបមាប់បោកអ្នក។ សូមទូរស័ព្ទបៅបេខបសវាបបបមើ សមាជិកដែេមានបៅបេើកាតសមាគា េ់របស់បោកអ្នក។

Persian Farsi:

برای این . در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد:توجه منظور با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید

4813-6644-7606, v. 5

AmeriHealth Caritas VIP Next, Inc.
220 Continental Drive, Suite 300
Newark, DE 19713

AMENDMENT TO THE EVIDENCE OF COVERAGE

This amendment applies to the Evidence of Coverage with the form number listed below.

ACDE Ind DE PY23 - EOC – 20220808

These changes become effective January 1, 2024.

A. The page headers are amended to change the plan year from 2023 to 2024, to read as follows:

   2024 Evidence of Coverage for AmeriHealth Caritas VIP Next, Inc.

B. The cover page is amended to change the plan year from 2023 to 2024, to read as follows:

   2024 EVIDENCE OF COVERAGE

C. The "Definition of Important Words Used In This Document" section is revised to change the definition "**AmeriHealth Caritas Next Telemedicine**" to "**AmeriHealth Caritas Next Virtual Care 24/7**." The term "**telemedicine services**" is changed to "**virtual care services**." The definition is to read as follows:

   - **AmeriHealth Caritas Next Virtual Care 24/7 —** The preferred vendor with whom we have contracted to provide **virtual care services** to our **members**. Our preferred vendor contracts with **providers** to render **virtual care services** to our **members**.

D. The "Definition of Important Words Used In This Document" section is revised to remove "Services limited to 100 visits per benefit period." from the definition of "**Home health care**," as this policy's home health care limitation can be found on your Schedule of Benefits. The definition is to read as follows:

   - **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.

E. The "Definitions of Important Words Used in this Document" section is revised to add a definition for "**Serious and complex condition or illness**," to read as follows:

   - **Serious and complex condition or illness —** an acute condition or chronic illness that requires specialized treatment over a period of time to avoid injury, or impairment that results in, or is likely to result in, any of the following:
     - Death or permanent harm;
     - Significant decline in physical, mental, or psychosocial functioning that is not solely due to the normal progression of a disease or aging process;

- Loss of limb, or disfigurement;
- Avoidable pain that is excruciating, and more than transient; or
- Other serious harm that creates life-threatening complications/conditions.

F. The "Definitions of Important Words Used in this Document" section is revised to change the definition of "**Telemedicine Services**" to "**Virtual care services**" and is placed in alphabetical order by its new name after "**Utilization Review Organization**." The revised definition is to read as follows:

- **Virtual care services —** Includes evaluation, management and consultation services with a professional **provider** for **behavioral health** and nonemergency medical issues via an interactive audio or video telecommunications system.

G. The "Eligibility and Termination" section, "Payment of premiums" subsection is revised to change the grace period for non-federal premium subsidy (Advance Premium Tax Credit) members from 15 days to 31 days to read as follows:

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. A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. If you are receiving a federal **premium** subsidy (Advance Premium Tax Credit) your grace period will be 3 months, and your coverage will remain in force during the grace period. If we do not 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. We will also notify the **subscriber** of the termination if the **premium** hasn't been received within the grace period.

H. The section entitled "How To Use Your Health Plan" is revised to add additional language to the following paragraph, to read as follows:

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** and you are in active treatment or terminally ill, AmeriHealth Caritas Next will continue to cover **covered health services** at the **member's** in-network cost share for up to 90 days. Please refer to the "Continuity/transition of care" section of this **policy** for additional information.

I. The "How to Use Your Health Plan" section is revised to bold the defined term "**serious and complex condition or illness**," add a 90-day coverage period for continuity/transition of care from an in-

network provider who stops participating in our network, and add additional coverage details regarding your continuity/transition of care benefit. In addition, a duplicate paragraph from the Evidence of Coverage's next section has been removed. The section is to read as follows:

Continuity/transition of care
Subject to **prior authorization** and **medically necessary** criteria review, 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 **out-of- network covered health services** with your treating **provider** for any medical or **behavioral health** condition currently being treated at the time of the **member's** enrollment in our plan. If the **member** is pregnant and in their second or third trimester, pregnancy-related services will be covered through 60 calendar days postpartum.

If an **in-network provider** or **in-network facility** stops participating in our **network,** they become an **out-of-network provider** or **out-of-network facility**. You may continue receiving care from that **out-of-network provider** or **out-of-network facility** through your continuity/transition of care coverage if when the in-network provider or in-network facility stops participating in our network you are:

- undergoing a course of treatment for a **serious and complex condition or illness;**
- undergoing a course of institutional or inpatient care from the provider or facility; scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

This coverage will end when treatment for the condition is completed or you change **providers** to a **network provider**, whichever comes first. This coverage is provided for a maximum of 90 days. We will notify you if your **in-network provider** or **in-network facility** becomes an **out-of-network provider** or **out-of-network facility**. The **out-of-network provider** or **out-of-network facility** that is treating you is prohibited from billing you more than your **in-network** cost-share for up to 90 days after you are notified.

In order to receive these services you must obtain **prior authorization** from the **health benefit plan**. Pregnant **members** who have started prenatal care with a **provider** or facility who stops participating in our **network** can continue receiving pregnancy-related services, including postpartum care through 60 calendar days after the birth. This continuity of care allowance does not apply to **providers** whose participation as **network providers** has been terminated for cause by the plan.

If you are determined to be terminally ill when your **provider** or facility stops participating in our **network**, or at the time you enroll in our plan, and your **provider** or facility was treating your terminal illness before the date of the **provider's** or facility's termination or your new enrollment in our plan, you can continue to receive care from that **provider** or facility. However, this is only true for services that directly relate to the treatment of your illness or its medical manifestations. This coverage is provided until you select another **network facility** or **network provider** as your treating physician or you reach your continuity/transition of care 90-day coverage maximum, whichever is shorter.

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 are not **medically necessary** will not be eligible for coverage. They will not be applied to **deductibles** or out-of-pocket amounts.

J. The "How to Use Your Health Plan," "Prior authorization," "Behavioral health services requiring prior authorization" subsection is revised as follows:
   - "Professional treatment services in facility based crisis programs" is replaced with "Crisis intervention services."
   - "Intensive outpatient treatment for opioid substance use treatment" is changed to "Intensive outpatient treatment."
   - Reordered in alphabetical order.

   The subsection is to read as follows:

   Behavioral health services requiring prior authorization

   - All out-of-network services except **emergency** care
   - Ambulatory detoxification
   - Crisis intervention services
   - Intensive outpatient treatment
   - Electroconvulsive therapy (ECT)
   - Mobile crisis management
   - Nonhospital medical detoxification
   - **Partial hospitalization**
   - Psychiatric inpatient hospitalization
   - Psychological testing

K. The "Covered Health Services" section, "Telemedicine services" subsection, is revised as follows:
   - "**Telemedicine services**" is changed to "**Virtual care services**."
   - "**telemedicine services**" is changed to "**virtual care services**."
   - "**AmeriHealth Caritas Next Telemedicine**" is changed to "**AmeriHealth Caritas Next Virtual Care 24/7**."
   - "$0 cost share" is changed to "no cost."
   - The paragraph is modified for benefit clarity.
   - Reordered in this section by its new name to appear just after "Urgent care services."

   The subsection is to read as follows:

   Virtual care services
   Virtual care services are covered at no cost when received through an **AmeriHealth Caritas Next Virtual Care 24/7 in-network provider**. Certain specialty services including pediatrics are not eligible for **AmeriHealth Caritas Next Virtual Care 24/7**. **Virtual care 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 **virtual care services** are available.

L. A new section entitled “Additional Covered Health Services and Programs” is added to the Evidence of Coverage, following “Covered Health Services.” The added section is to read as follows:

Additional Covered Health Services and Programs

AmeriHealth Caritas Next provides coverage for additional **covered health services** and programs. These **covered health services** and programs are available to you as long as you are active on this **policy**. Some programs are only available to eligible members based on a clinical assessment performed by our case management team. If your coverage ends under this policy, all incentives, memberships, vouchers, rewards, or benefits being provided will also end. Benefits provided are in addition to the benefits described in this **policy** and certain terms and conditions may apply. The programs and their offerings are subject to change as we continue to improve your care experience. If you would like additional information on our current programs offered, contact the Member Services phone number on the back of your member ID card.

Disease management or wellness programs
AmeriHealth Caritas Next has a case management team dedicated to supporting your medical, behavioral health, and social needs. It provides customized, integrated, person-centered care addressing all aspects of **member** wellness. The case management team will assess your needs and may direct you to one of our disease management or wellness programs that provides education, support, and care coordination services. Member eligibility for these programs is determined by the case management team based on clinical assessment.

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

Optum Obstetrical Homecare program
AmeriHealth Caritas Next makes available to qualifying members the Optum Obstetrical Homecare program. This program is designed to provide ongoing education at various stages of pregnancy, identify warning signs of preterm labor through weekly physician-prescribed assessments, and assist in the identification of high-risk pregnancy conditions. Homecare visits will be performed by an experienced nurse, and will include education and materials related to pregnancy, preterm labor, and high-risk pregnancy. The program includes access to 24/7 telephonic nursing and pharmacist support. Member eligibility for this program is determined by the case management team based on clinical assessment.

Tobacco cessation program
AmeriHealth Caritas Next makes available to qualifying **members** a tobacco cessation program at no cost. The tobacco cessation program provides **members** with personalized individualized information, support, tools, and coaching to achieve health goals related to tobacco cessation. Tobacco cessation medications such as nicotine gum, lozenges, patches, buprenorphine (smoking deterrent formulation) and varenicline tartrate are also available to members with a prescription. Please see the formulary for more details.

Weight Watchers program

AmeriHealth Caritas Next makes available to **members** from ages 15 to 64 vouchers for membership with Weight Watchers for up to 28 weeks at no cost.