2026 EVIDENCE OF COVERAGE

AmeriHealth Caritas North Carolina, Inc.

Individual member health maintenance organization (HMO) policy

This is a legal contract. Please read your policy carefully.
Important cancellation information: Please read the provision entitled "Termination," found on page 14 of this policy.

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

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

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

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

Renewal

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

If you have any questions about this document or how to use your health plan, please feel free to contact our Member Services team at 1-833-613-2262 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m., excluding holidays, for additional information.

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DEFINITIONS OF IMPORTANT WORDS USED IN THIS DOCUMENT

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

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

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

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

treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

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

- **Enrollment Date** – The date of enrollment, or if earlier, the first day of the waiting period for the enrollment
- **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.
- **Evidence of Coverage (EOC) and disclosure information** — This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our health plan.
- **Formulary/formulary drugs** — A list of medications that we cover. Products that are on the formulary generally cost less than products that are not on the formulary.
- **Foster Child** —A minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.
- **Generic drug** — A prescription drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as the brand name drug. Generally, a generic drug works the same as a brand name drug and costs less.
- **Grievance** – A written complaint submitted by a Covered Person about any of the following:
    a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care services in question is not a grievance if the exclusion of the specific service requested is clearly stated in the Certificate of Coverage.

    b. Claims payment of handling; or reimbursement for services

c. The contractual relationship between a Covered Person and an insurer

- **Habilitative services** — Health care services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech and language therapy, and other services for people with disabilities in inpatient and/or outpatient settings.

- **Health Benefit Plan** – means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
    a. Accident.
    b. Credit.
    c. Disability income.
    d. Long-term or nursing home care.
    e. Medicare supplement.
    f. Specified disease.
    g. Dental or vision.
    h. Coverage issued as a supplement to liability insurance.
    i. Workers' compensation.
    j. Medical payments under automobile or homeowners.
    k. Hospital income or indemnity.
    l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self insurance.
- **Health Care provider** – Any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy.
- **Health Care Services** – Services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- **Home Health Aide** — Provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out prescribed exercises). Home health aides do not have a nursing license or provide therapy.
- **Home health care** — Health care services provided to the member in the home for treatment of an illness or injury by an organization licensed and approved by the state to provide these services.

- **Hospice** — A program for members who have six months or less to live that addresses the physical, psychological, social, and spiritual needs of the member and their immediate family.
- **Hospital** — A facility for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses. **Hospital** does not mean health resorts, spas, or infirmaries at schools or camps.
- **Infertility** — The inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.
- **Inpatient rehabilitation facility** — A facility that provides rehabilitative health services on an inpatient basis, as authorized by law.
- **Insurer** – An entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.
- **Managed Care Plan –** A health benefit plan in which an insurer either (1) requires a covered person to use or (2) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the insurer.
- **Maximum out-of-pocket** amount — The most that you pay out **of** pocket during the calendar year for in-network covered services, including **deductible**s and any cost-sharing. Amounts you pay for your premiums and prescription drugs do not count toward the maximum out-of-pocket amount.
- **Medically Necessary –** Medical Necessity or Medically Necessary means those covered services or supplies that are:
    - Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes
    - Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
    - Within generally accepted standards of medical care in the community ○ Not solely for the convenience of the insured, the insured's family, or the provider

  For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.
- **Member** (**member** of our health plan, or "health plan member") — A person who is eligible to get **covered health services**, who has enrolled in our health plan, who has paid any necessary premium or on whose behalf any necessary premium has been paid, and whose enrollment has been confirmed. A member includes the subscriber and any dependents.
- **Network** — The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered

services to our members. They also agree to accept our payment and any health plan cost-sharing as payment in full.

- **Network pharmacy** — A pharmacy where members of our health plan can get their prescription drug benefits. We call them network pharmacies because they contract with our health plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- **Network provider** — Providers who have an agreement with our health plan to provide covered services to our members and to accept our payment as payment in full. Our health plan pays network providers based on the agreements we have with the providers. Network providers may also be referred to as “health plan providers.”
- **Noncertification** – a determination by an Insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.
- **Out-of-network pharmacy** — A pharmacy that doesn’t have a contract with our health plan to coordinate or provide covered drugs to members of our health plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our health plan unless certain conditions apply.
- **Out-of-network provider** or **out-of-network facility** — A provider or facility with which we do not have an agreement to coordinate or provide covered services to members of our health plan. Out-of-network providers are not employed, owned, or operated by our health plan and are not under contract with us to deliver covered services to you.
- **Out-of-pocket costs** — See the definition for cost-sharing above. A member’s cost-sharing requirement to pay for a portion of services or drugs received or any deductible amount is also referred to as the member’s out-of-pocket cost requirement.
- **Partial hospitalization** — Services received from a free-standing or hospital-based program that provides services at least 20 hours per week and continuous treatment for at least three hours but no more than 12 hours per 24-hour period.
- **Participating provider** - a provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the insurer, other than coinsurance, copayments, or deductibles.

- **Plan year** — This is typically a calendar year, but if your initial effective date is other than January 1, your initial plan year will be less than 12 months, starting on the effective date and running through December 31 of the same year.
- **Policy** — The document that describes the agreements between the health plan and the **member**. Your **policy** includes this document, the Summary of Benefits, your application, and any amendments or riders.
- **Premium** — The periodic payment to AmeriHealth Caritas North Carolina or a health care plan for health and/or prescription drug coverage.
- **Primary care provider** — The doctor or other provider (e.g., a physician in family medicine, general medicine, internal medicine, or pediatric medicine; advanced practice nurse; certified nurse practitioner; or physician's assistant) you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she may also talk with other doctors and health care providers about your care and refer you to them.
- **Prior authorization** — Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our health plan.
- **Prosthetics and orthotics** — These are medical devices ordered by your doctor or other health care **provider**. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.
- **Provider** - is the general term we use for doctors, other health care professionals, hospitals, and health care facilities that are licensed or certified under Chapter 90 of the North Carolina General Statutes or the laws of another state to provide health care services.
- **Quantity limits** — A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount that we cover per prescription or for a defined period of time.
- **Rehabilitation services** — These services include physical therapy, speech and language therapy, and occupational therapy. Services may be provided on an inpatient or outpatient basis and may be subject to limitations as outlined in the Summary of Benefits.
- **Rider** — An amendment to this Evidence of Coverage that may modify the covered benefits.
- **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.

- **Service Area** – Service area means the geographic area in North Carolina as described by the HMO pursuant to G.S. 58-67-10(c)(11) where an HMO enrolls persons who either work in the service area, reside in the service area, or work and reside in the service area, as approved by the Commissioner pursuant to G.S. 58-67-20.
- **Sexual Dysfunction** – Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.
- **Skilled nursing facility (SNF) care** — Skilled nursing care and rehabilitation services provided continuously and daily in a skilled nursing facility. Examples of SNF care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.
- **Special enrollment period** — An opportunity to enroll in a health plan outside of the annual open enrollment period based on specific qualifying events.
- **Stabilize** – To provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.
- **Step therapy** — A pharmacy management tool that requires you to first try another drug to treat your medical condition before we will cover the drug your **provider** may have initially prescribed.
- **Subscriber** — The covered person who is not a dependent and who is properly enrolled under this policy, on whose behalf this policy is issued.
- **Summary of Benefits** — A document of coverage that identifies the member, applicable copayments, coinsurance, deductibles, maximum out-of-pocket amount, and benefit limits for covered health services. Any time we issue a new Summary of Benefits, it will replace any prior Summary of Benefits on the effective date of the new Summary of Benefits.
- **Urgent care services** — Services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. **Urgent care services** may be furnished by **network providers** or **out-of-network providers** when **network providers** are temporarily unavailable or inaccessible.

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

    a. Ambulatory review. - Utilization Review of services performed or provided in an outpatient setting.

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

- **Utilization Review Organization (URO) –** An entity that conducts Utilization Review under a Managed Care Plan but does not mean an Insurer performing Utilization Review for its own Health Benefit Plan.
- **Virtual care services**—Includes evaluation, management, and consultation services with a professional provider for behavioral health and nonemergency medical issues via an interactive audio/video telecommunications system.

ELIGIBILITY AND TERMINATION

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

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

Eligible dependents

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

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

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

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

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

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

When coverage begins

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

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

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

Enrollment periods

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

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

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

Enrolling dependents

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

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

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

Changes in eligibility

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

End of coverage — termination of enrollment

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

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

Payment of premiums

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

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

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

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

Reinstatement of coverage

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

Certificate of creditable coverage

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

HOW TO USE YOUR HEALTH PLAN

Our plan uses network providers to provide covered services to you. This means that we will not pay for services you might receive from out-of-network providers unless you have an emergency medical condition or we authorize services from an out-of-network provider because the medically necessary services you need are not available from a network provider. You can find a provider in our network online at https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&brandCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=NCEX or by calling our Member Services number on your member ID card. Network providers are not employees of our plan.

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

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

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

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

Choosing a primary care provider (PCP)

Once you enroll, you and any covered dependents in this plan must choose a PCP. If you do not select one, we will pick one for you. You can also change your PCP if the PCP is no longer a network provider. Your PCP will oversee your care and coordinate services from other network

providers when needed. In certain instances, if you have a serious condition or disease, you may be able to select a specialist to serve as your PCP subject to our health plan's approval. You will be allowed to choose a network pediatrician as the PCP for any covered dependents under age 18.

Continuity/transition of care

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 or honor an existing **prior authorization**. If the **member** is pregnant and in their second or third trimester, pregnancy-related services will be covered through 60 calendar days postpartum.

If a **network provider** or **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 **network provider** or **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 is provided through completion of treatment, until you select another **network provider** or **network facility** as your treating physician, or until the next open enrollment period offered by AmeriHealth Caritas Next, whichever is longer. 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** who is treating you is prohibited from billing you more than your in-network cost-share for up to 90 days after you are notified.

For these services to be covered, 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 time 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 at the time a **provider** or **facility** stops participating in our network, or at the time of enrollment under our plan, and the **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, the transitional period shall extend for the remainder of your life with respect to care directly related to the treatment of your terminal illness or its medical manifestations.

Medical necessity

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

Prior authorization

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

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

Physical health services requiring prior authorization

- All out-of-network services excluding emergency services.
- All services that may be considered experimental and/or investigational.
- All miscellaneous services.
- Elective air ambulance.
- Inpatient hospital services:
    - All inpatient hospital admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation.
    - Behavioral health.
    - Obstetrical admissions and newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section.
    - Medical detoxification.
    - Elective transfers for inpatient and/or outpatient services between acute care facilities.
    - Long-term care initial placement (while enrolled with the plan — up to 90 days).
- Gastroenterology services.
- Gender reassignment services.

- Genetic testing.
- Home-based services.
- Home health care (physical, occupational, and speech and language therapy) and skilled nursing (after six combined visits, regardless of modality).
- Home infusion services and injections.
- Home health aide services.
- Private duty nursing (extended nursing services).
- Personal care services, or assistance with activities of daily living including bathing, eating, dressing, toileting, and walking.
- Dental anesthesia.
- Hospice inpatient services.
- First- and second-trimester terminations of pregnancy require PA 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.
- Private duty nursing.
- Rehabilitation services and habilitative services (chiropractic services and speech and language, occupational, and physical therapy):
    - Chiropractic services, and speech and language, occupational, and physical therapy require PA after initial assessment or reassessment. This applies to private and outpatient facility-based services.
- Transplants, including transplant evaluations.
- Chemotherapy.
- Clinical trials.
- DME:
    - Items with billed charges equal to or greater than $750, including **prosthetics** and **custom orthotics**
    - DME leases or rentals and custom equipment
    - All unlisted or miscellaneous items, regardless of cost
    - Negative pressure wound therapy
- Hearing aids:
    - Any newly fit monaural hearing aid (PA required over $750).
    - Any replacement hearing aid (PA required over $750).
    - All newly fit binaural hearing aids (PA required over $750).
    - Ear molds (PA required over $750).

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

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

Physical health services that do not require PA

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

The following services will not require PA:

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

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

Behavioral health services requiring PA

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

Behavioral health services that do not require authorization

- Diagnostic assessment
- Medication-assisted treatment (MAT)
- Mental health or substance dependence assessment
- Outpatient psychiatric, substance use disorder, and medication management services not specified as requiring **prior authorization**. For specific services, please have your **provider** refer to the Prior Authorization Lookup Tool on our **PA** section of our Plan Website.

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.

Utilization management

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

We will:

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

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

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

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

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

If we certify a **covered health care service**, we will notify the **member** and the member's **provider**. For a noncertification, we will notify the **member** and the member's **provider** and send written or electronic confirmation of the noncertification to the member and the **provider**. For concurrent reviews, we will be responsible for **covered health care services** until the member has been notified of the noncertification (i.e., a denial does not become effective until notice is provided to the covered person). We will decide on retrospective reviews within 30 days of our receipt of the request. We will notify you and your **provider** in writing of our decision. If we deny the service as a result of the review, we will send written notice to both you and your provider within threebusiness days after the determination is made. We remain responsible for **covered health care services** until you have been notified of the noncertification.

If your request is not approved we will issue a noncertification also called an **adverse benefit determination**. If you do not agree with our decision to deny your request, you have a right to appeal the decision. Please see the appeals section of this **policy** for additional information on how to appeal an **adverse benefit determination**.

To obtain PA or verify requirements for inpatient or outpatient services, including which other types of facility admissions require PA, you or your provider can call our Member Services team at 1-833-613-2262 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m., excluding holidays.

Cost-sharing requirements

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

- Your deductible is the amount you will have to pay each year for covered services before the health plan begins to pay. Any coinsurance or copayment amounts will not apply to your deductible but will count toward your maximum out-of-pocket amount.

- Coinsurance is your share of the cost for covered services or prescription drugs that you pay, usually shown as a percentage.
- A copayment or copay is your share of the cost for covered services or prescription drugs that you pay as a set dollar amount.
- The maximum out-of-pocket amount is the most you will pay out of pocket during the year for covered services. This does not include any amounts you pay for premiums.

COVERED HEALTH SERVICES

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

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

Your cost-share responsibility for the **covered health services** you receive are determined based on where the services are provided. For example, if you receive allergy testing and treatment in an office visit setting, your specialist cost-share responsibility will apply. However, if you receive allergy testing provided by an outpatient laboratory center, your laboratory outpatient professional services cost-share responsibility will apply. Please refer to your **Schedule of Benefits** to determine any limitations and cost-share responsibility that may apply to your **covered health services**.

The **Schedule of Benefits** and other **policy** documents are available on request by contacting our Member Services team at 1-833-613-2262 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m., excluding holidays

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

Accident-related dental services

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

Allergy testing and treatment

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

Ambulance services

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

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

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

Nonemergency air transportation requires PA.

Autism spectrum disorders (ASDs)

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

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

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

Bariatric surgery

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

Biofeedback

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

Blood Products

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

Blood Exclusion

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

Bone mass measurement services

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

Chemotherapy services

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

Complications of Pregnancy

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

Congenital cleft lip and palate care and treatment

We will cover, for covered persons younger than 18 years of age, medically necessary care and treatment including, but not limited to, oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate; prosthetic treatment such as obturator, speech appliances and feeding appliances; orthodontic treatment and management; prosthodontic treatment and management; otolaryngology treatment and management; audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices and physical therapy assessment and treatment. If a member with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by this plan.

Diabetes services and supplies

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

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

- Insulin pumps and supplies needed for the insulin pumps.

Diagnostic services — outpatient

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

Dialysis services — outpatient

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

DME

We cover medically necessary DME ordered or provided by a physician. DME may require PA, and we reserve the right to approve rental instead of purchase of the DME. Examples of DME include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), prosthetics, and wheelchairs. Please refer to your **Schedule of Benefits** of Benefits for details and any limitations to coverage.

Emergency services

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

Family planning services

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

Hearing aids and hearing services

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

- Cochlear and auditory brainstem implant external parts replacement and repair.
- Soft band and implantable bone conduction hearing aid external parts replacement and repair.
- Cochlear and auditory brainstem implants.

- Implantable bone conduction hearing aids (bone-anchored hearing aid [BAHA]).

Prior authorization may be required for hearing services.

Home health care

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

Hospice care

Hospice care is a comprehensive program of care that addresses the physical, social, and spiritual needs of a terminally ill patient and provides support for the immediate family. Services will be covered when recommended by a physician and received from an appropriately licensed hospice agency or inpatient hospice program.

Hospital services

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

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

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

Infertility services

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

Mental health and substance use services

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

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

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

Coverage for medically necessary services applies whether treatment is voluntary on the part of the covered person or court-ordered as the result of contact with the criminal justice or legal systems.

Other Provider Office Visits

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

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

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

Outpatient Surgery Physician/Surgical Services

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

Pediatric vision services

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

Physician services for sickness and injury

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

Pregnancy services

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

Preventive health care services

We cover any preventive services required by federal and state laws or regulations. Your **deductible**, **copayment**, or **coinsurance** amounts will not apply if these services are received from a **network provider**. Services 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 suitable cost-share described in your **Schedule of Benefits**.

Federally mandated preventive health care services

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

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

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

State-mandated preventive health care services

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

- Cervical cancer screening — Examination and laboratory tests for early detection and screening including Pap smear, liquid-based cytology, and human papillomavirus detection; this will follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- Certain clinical trials as described in North Carolina state law (G.S. 58-3-255).
- Colorectal cancer screening — Annual examinations and laboratory tests for colorectal cancer are covered for any member who is at least age 45 or is younger than age 45 but is at high risk for colorectal cancer.
- Medically necessary care and treatment for medically diagnosed congenital defects and abnormalities, including cleft lip and palate.
- Hospital and anesthesia charges for certain dental procedures for members less than age 19 or for members with physical or mental disabilities if provided by a network hospital or ambulatory surgical center.
- Diagnosis and treatment of lymphedema.
- Mammograms — We cover one baseline mammogram for any female member ages 35 – 39; beginning at age 40, one screening mammogram will be covered per female member per benefit period.
- Newborn hearing screening.
- Certain off-label prescription drugs used for cancer treatment.

- Ovarian cancer screening — For female members ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered.
- PSA test.

Primary Care Office Visits

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

Private duty nursing

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

Radiation therapy — outpatient

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

Rehabilitation services

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

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

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

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

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

Habilitative services

Medically necessary services for habilitative services, including occupational therapy, and physical therapy must be ordered by a physician and delivered by appropriately licensed medical

personnel. We will determine if the service is covered by reviewing both the skilled nature of the service and the need for physician management.

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

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

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

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. Routine foot care that is determined to be cosmetic in nature is excluded from coverage and will not be covered.

Sexual dysfunction

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

Skilled nursing facility services

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

- The skilled nursing facility is a **Network Provider.**
- The admission is ordered by the **Covered Person's** Attending Physician. We require written confirmation from the physician that skilled care is necessary.
- **Covered Services** must be of a temporary nature and must be supported by a treatment plan.
- **Covered Services** do not include custodial, domiciliary care, or long-term care admissions.

Specialist Visits

Office visits for specialty care services are covered.

Transplantation services

We will cover organ and tissue transplants when ordered by a physician, approved through PA, and when the transplant meets the definition of a covered health service (and is not an

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

Temporomandibular joint (TMJ) disorder

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

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

Urgent care services

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

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 specialties 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.

PRESCRIPTION DRUG BENEFITS

AmeriHealth Caritas Next strives to provide you with high-quality and cost-effective drug coverage.

We use AmeriHealth Caritas Next's Pharmacy Benefit Manager (PBM) to help manage your prescription drug benefit, including specialty medications. You will need to get your prescription medications filled from a network pharmacy to obtain coverage. Prescriptions can be filled at either a retail network pharmacy, through our mail-order network pharmacy, or a network specialty pharmacy. You will need to show your member ID card when you fill or obtain your prescription medications.

The prescription drug benefits do not cover all drugs and prescriptions. Some drugs must meet certain medical necessity guidelines before we can cover them. Your provider must ask us for prior authorization before we will cover these drugs.

Formulary
The list of prescription drugs covered under this plan is called a formulary. The formulary applies only to drugs you get at retail, mail-order, and specialty pharmacies. Along with the covered drugs, the formulary also allows you to review any limitations or restrictions such as prior authorization, step therapy, quantity limits, and age limits. The formulary does not apply to drugs you get if you are in the hospital. For our latest pharmacy benefit and formulary information please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-844-211-0968.**

The formulary is a closed formulary (i.e., products not listed are treated as nonformulary); however, drugs not on the formulary can still be requested, and our pharmacy benefits manager's coverage determination and prior authorization process may allow for nonformulary exceptions.

The formulary covers both brand (preferred and nonpreferred) and generic drugs and will determine what your out-of-pocket costs will be under our plan based on the drug tier. Please refer to your Summary of Benefits and Coverage for more information on copays and deductibles.

Covered prescription drugs and supplies
The prescription drug benefits cover many different therapeutic classes of drugs, which you can find at **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** You can use the searchable drug list, to search by the first letter of your medication, by typing part of the generic (chemical) or brand (trade) names, or by selecting the therapeutic class of the medication you are looking for.

Your prescription drug benefits cover 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

In addition to the covered prescription drugs and supplies listed in the Formulary, we may cover:

- Oral and injectable drug therapies used in the treatment of covered infertility services only when you have been approved for covered infertility treatment.

- Compounded medications: If at least one active ingredient requires a prescription by law and is approved by the U.S. Food and Drug Administration (FDA). Compounding kits that are not FDA approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call the Member Services team. Some compounded medications may be subject to prior authorization.

- We will also cover certain off-label uses of cancer drugs in accordance with state law. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following compendia: (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium; (2) The Thompson Micromedex DrugDex; (3) American Hospital Formulary Service; (4) Lexi-Drugs; or (5) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Included in the Formulary are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal individuals
- Hypodermic syringes or needles when Medically Necessary

Narrow Therapeutic Index (NTI) Drugs

AmeriHealth Caritas Next will cover certain Narrow Therapeutic Index (NTI) brand medications. The medication may first require a prior authorization to be covered.

The brand formulations of the following NTI medications are eligible for coverage:

- Carbamazepine
- Cyclosporine
- Digoxin
- Ethosuximide
- Levothyroxine sodium tablets
- Lithium
- Phenytoin
- Procainamide
- Tacrolimus
- Theophylline
- Warfarin sodium tablets

Preventive medications

Under the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), some preventive medications may be covered at no cost (copay, coinsurance, or deductible) for AmeriHealth Caritas Next members.

These include certain medications as follows:

- Bowel Preparations – for members from ages 45 to 75 years
- Oral Fluoride Supplementation – for members from ages 6 months to 5 years
- Moderate-intensity Statins – for member from ages 40 to 75 years
- Folic acid 400 to 800 mcg for members of childbearing age
- Aspirin 81mg to prevent or delay the onset of preeclampsia
- Tobacco Cessation
    - Nicotine gum
    - Nicotine lozenge
    - Nicotine patch
    - Bupropion HCL (smoking deterrent) tab ER 12hr 150 mg
    - Varenicline tartrate
- HIV Pre-exposure prophylaxis (PrEP):
    - Descovy (emtricitabine/tenofovir alafenamide), oral tablet 200mg-25mg
    - Emtricitabine-tenofovir df, oral tablet 200mg-300 mg
    - Apretude (cabotegravir) Intramuscular Suspension Extended Release 600 Mg/3Ml
- Breast Cancer primary prevention:
    - Anastrozole, oral tablet 1mg
    - Exemestane, oral tablet 25mg
    - Letrozole, oral tablet 2.5mg
    - Raloxifene HCL, oral tablet 60 mg
    - Tamoxifen citrate, oral tablet 10 mg and 20 mg
- Vaccines recommended by Advisory Committee on Immunization Practices (ACIP)
- Contraception: As a requirement of the Women's Prevention Services provision of the ACA, contraceptives are covered at 100% for generic products when prescribed by a participating network provider.
    - Contraceptive categories include*:
        - Oral contraceptives (Rx and over-the-counter [OTC])
        - Injectable contraceptives (Rx)
        - Barrier methods (Rx)**
        - Intrauterine devices**, subdermal rods** and vaginal rings (Rx)
        - Transdermal patches (Rx)
        - Emergency contraception (Rx and OTC)
        - Condoms (OTC)
        - Female condoms (OTC)
        - Vaginal pH modulators (Rx)
        - Vaginal sponges (OTC)
        - spermicides (OTC)

*Please see the formulary for the most up-to-date list of products.

** Certain drugs or products may be covered as a nonpharmacy benefit (e.g., infused, injected, or implanted drugs, which are covered under medical benefits).

Note: A prescription is required for all listed medications, including over-the-counter (OTC) medications.

Prescription drug benefit exclusions

What is not covered:

- Any drug products used exclusively for cosmetic purposes
- Experimental drugs, which are those that cannot be marketed lawfully without the approval of the FDA and for which such approval has not been granted at the time of their use or proposed use, or for which such approval has been withdrawn
- Prescription drugs that are not approved by the FDA
- Drugs on the FDA Drug Efficacy Study Implementation (DESI) list
- Immunization agents or vaccines not listed on the formulary. Some immunizations may be covered under the medical benefit.
- Medical supplies*
- Prescription and over-the-counter homeopathic medications
- Drugs that by law do not require a prescription (OTC) unless listed on the formulary as covered
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for children, and supplements for the treatment of mitochondrial disease)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- Prescriptions filled at pharmacies other than network-designated pharmacies, except for emergency care or other permissible reasons. An override will be required to allow the pharmacy to process the claim.
- Prescriptions filled through an internet pharmacy that is not a verified internet pharmacy practice site certified by the National Association of Boards of Pharmacy
- Prescription medications, when the same active ingredient, or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication, has become available over the counter. In these cases, the specific medication may not be covered, and the entire class of prescription medications may also not be covered.
- Prescription medications when co-packaged with non-prescription products
- Medications packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the formulary.
- Drugs used for erectile dysfunction or sexual dysfunction
- Drugs used for weight loss
- Bulk Chemicals
- Repackaged products

* Certain drugs or products may be covered as a non-pharmacy benefit (e.g., infused, injected, or implanted drugs, which are covered under medical benefits).

For our latest pharmacy benefit and formulary information, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-833-613-2262**.

Formulary Changes
The formulary is occasionally subject to change. If a change negatively affects the medication you are taking, we will provide written notice to you before the change takes effect. We will work with you and your prescriber to transition to another covered medication if you are on a long-term prescription.

Formulary Tier Explanation

Tier 1 — Generics

Tier 2 — Preferred Brand

Tier 3 — Nonpreferred Brand

Tier 4 — Specialty

Please see your specific "metal level" coverage for co-pay and coinsurance amounts.

Prior Authorizations, step-therapy, quantity limits, age limits, generic drug program, and other formulary tools

AmeriHealth Caritas Next's PBM may use certain tools to help ensure your safety and so that you are receiving the most appropriate medication at the lowest cost to you. These tools include prior authorization, step therapy, quantity limits, age limits, and generic drug program. Below is more information about these tools.

Prior Authorizations (PA)
There are restrictions on the coverage of certain drug products that have a narrow indication for usage, may have safety concerns, and/or are extremely expensive, requiring the prescribing provider to obtain prior authorization from us for such drugs. The formulary states whether a drug requires prior authorization.

Step therapy (ST)
Step therapy is a type of prior authorization program (usually automated) that uses a stepwise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first before other medications may be covered. Members must first try one or more medications on a lower step to treat a certain medical condition before a medication on a higher step is covered for that condition. If your Provider advises that the medications on lower step(s) is not right for your health condition and that the medication on higher step is Medically Necessary, your Provider can submit a request for approval.

Quantity limits (QL)
To make sure the drugs you take are safe and that you are getting the right amount, we may limit how much you can get at one time. Your Provider can ask us for approval if you need more than we cover.

Quantity limits will be waived under certain circumstances during a state of emergency or disaster.

Age limits (AL)
Age limits are designed to prevent potential harm to members and promote appropriate use. The approval criteria are based on information from the FDA, medical literature,

actively practicing consultant physicians and pharmacists, and appropriate external organizations.

If the prescription does not meet the FDA age guidelines, it will not be covered until prior authorization is obtained. Your Provider can request an age limit exception.

Generic drugs
Generic drugs have the same active ingredients and work the same as brand-name drugs. When generic drugs are available, we may not cover the brand-name drug without granting approval. If you and your provider feel that a generic drug is not right for your health condition and that the brand name drug is medically necessary, your provider can ask for prior authorization.

New-to-market drugs
We review new drugs for safety and effectiveness before we add them to our formulary. A Provider who feels a new-to-market drug is medically necessary for you before we have reviewed it can submit a request for approval.

Non-formulary drugs
While most drugs are covered, a small number of drugs are not covered because there are safe, effective, and more affordable alternatives available. All of the alternative drug products are approved by the FDA and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. If you and your provider feel that a formulary drug is not right for your health condition and that the non-formulary drug is medically necessary, your provider can ask for an exception request.

Non-covered drugs with over-the-counter alternatives

AmeriHealth Caritas Next does not cover select prescription medications that you can buy without a prescription, or "over-the-counter." These drugs are commonly referred to as OTC medications.

In addition, when OTC versions of a medication are available and can provide the same therapeutic benefits, AmeriHealth Caritas Next may no longer cover any of the prescription medications in the entire class. For example, non-sedating antihistamines are a class of drugs that give relief for allergy symptoms. Because many non-sedating antihistamines are available over-the-counter, AmeriHealth Caritas Next does not cover them.

Please refer to the pharmacy formulary for a list of covered medications. As always, we encourage you to speak with your provider about which medications may be right for you.

Prior Authorization and Exception requests

For formulary drugs that have restrictions such a prior authorization (PA), step therapy (ST), quantity limitations (QL), and age limitations (AL), a prior authorization request may be submitted for decisions. AmeriHealth Caritas Next's PBM will review the requests and will determine if a request meets the clinical drug criteria requirements.

For non-formulary drugs, non-formulary exception requests can be made. Non-formulary exception requests are reviewed on a case-by-case basis. Your provider will be asked to provide medical reasons and any other important information about why you need an exception.

AmeriHealth Caritas Next's PBM will review the requests and will determine if a request is consistent with our medical necessity guidelines.

We will cover non-formulary prescription drugs if the outpatient drug is 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 U.S. FDA for at least one 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;

and

- There are no formulary drugs that can be taken for the same condition. If there are formulary alternatives to treat the same condition then documentation must be provided that the member has had a treatment failure with, or is unable to tolerate, two or more formulary alternative medications.
- Prescription drug samples, coupons, or other incentive programs will not be considered a trial and failure of a prescribed drug in place of trying the formulary-preferred or nonrestricted access prescription drug.

AmeriHealth Caritas Next's PBM will review the request. If the requested drug is approved, it will be covered according to our medical necessity guidelines. If the request is not approved then you, your authorized representative, or your provider can appeal the decision.

If the request for a non-formulary drug is approved, the medication will be covered on the highest tier.

You, your authorized representative, or your provider can visit our website to review the formulary and find covered drugs. You can access a searchable and a printable formulary on our website at **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx**

You*, your authorized representative*, or your provider can request for both formulary drug prior authorizations (PA, ST, QL, and AL) and non-formulary exceptions in the following ways:

- Electronically: directly to AmeriHealth Caritas Next's PBM, through Electronic Prior Authorization (ePA) in your Electronic Health Record (EHR) tool software, or you can submit through either of the following online portals:
  - CoverMyMeds
  - Surescripts
- By fax: 1-855-756-9901 for standard (nonurgent) requests 1-866-533-5497 for expedited (fast)* requests
- By mail:
- 200 Stevens Drive
  Philadelphia, PA 19113 CC: 236
- By telephone at: 1-844-280-9131

*If you or your authorized representative submit the request for a prior authorization or non-formulary exception your provider must provide follow-up clinical documentation.

Once all necessary and relevant information to make a decision is received, AmeriHealth Caritas Next's PBM will review the request. If the request is approved, they will provide an approval response to your provider with a duration of approval. If the request is denied, they will provide a denial response to you and your provider.

Prior authorization and non-formulary exception requests will be completed and notifications sent within the following timeframes:

- Standard (non-urgent): no later than **72 hours** after we receive the request and any additionally required information.
- Expedited (fast)*: no later than **24 hours** after we receive the request and any additionally required information.

*Expedited (fast) request can be made based on exigent circumstances. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug. You can indicate your exigent circumstance on the form and request an expedited review.

If the prior authorization request is denied and you feel we have denied the request incorrectly, you may challenge the decision through the internal appeal process of AmeriHealth Caritas Next.

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider, or a lawyer to help you. You can call AmeriHealth Caritas Next at **1-833-613-2262 (TTY 711)** if you need help with your appeal request. It is easy to ask us for an appeal by using one of the options below:

- Mail: Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 180 days after the date on this notice.
- Fax: Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax numbers listed on the form.
- By phone: Call **1-833-613-2262 (TTY 711)** and ask for an appeal.

If a decision is made to uphold the denial pursuant to our internal dispute process, then upon exhaustion of that process, you have the right to pursue 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).

An expedited external review may be warranted upon exhaustion of the internal appeals process if your health could be seriously compromised by having to wait for resolution of a standard external review. If your request for a standard external review is accepted, it is decided within 45 days of receipt of your request. If your request for an expedited external review is accepted, it is decided within three (3) days of your request. Alternatively, and depending on the extent to which you or your provider believe that your health could be seriously harmed by waiting for resolution of AmeriHealth Caritas Next's internal dispute process, you may request and be granted an immediate expedited external review by the IRO. Once again, requests for expedited external review are resolved within three (3) days.

We must follow the IRO's decision. If the IRO reverses our decision on a standard external review, we will provide coverage for the drug product within three days of receiving notice of the reversal. If the IRO reverses our decision on an expedited external review, we will provide coverage for the non-formulary within one day of receiving notice. An IRO review may be requested by the member, member's representative, or member's prescribing provider by web, mail, or fax at the address below:

- Web: **External Review Request Form** can be found at: **https://secure1.ncdoi.com/consumer/ext_review_entry.jsp.** FAQs and more info about external review at **https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review .**

- Mail: NC Department of Insurance
  3200 Beechleaf Court
  Raleigh, NC 27604
- Phone: **1-855-408-1212**
- Fax: **1-866-582-2053**

For more information on appeals please see the section on appeals of the Member Handbook.

Non-formulary exception request denial rights

For non-formulary exception request denials, you also have the right to pursue 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).

You may exercise your right to external review with an Independent Review Organization (IRO) upon initial denial or following a decision to uphold the initial denial pursuant to the internal appeal process of AmeriHealth Caritas Next. If a decision is made to uphold the initial denial, your denial notice will explain your right to external review and provide instructions on how to make this request. An IRO review may be requested by the member, member's representative, or member's prescribing provider by contacting AmeriHealth Caritas Next via mail, phone, or fax at the following address:

- Mail: Member Appeals AmeriHealth Caritas Next P.O. Box 7417 London, KY 40742-7417
- Phone: 1-833-613-2262 (TTY 711)
- Fax: 1-844-201-6798

An expedited external review may be warranted if based on exigent circumstances, your request for a standard external review is accepted, it is decided within 72 hours of receipt of your request. If your request for an expedited external review is accepted, it is decided within 24 hours of receipt of your request.

We must follow the IRO's decision. If the IRO reverses our decision on a standard external review, we will provide coverage for the non-formulary item for the duration of the prescription. If the IRO reverses our decision on an expedited external review, we will provide coverage for the non-formulary item for duration of the exigency.

Filling prescriptions at the Pharmacy

Retail Pharmacy – you can fill up to a 30 day supply
Mail Order – you can fill a 31-90 day supply
Specialty – you can fill up to a 30 day supply

Retail pharmacy
You can fill your prescriptions at any of our contracted pharmacies nationally. Certain medications that are considered maintenance medications can be filled for up to a 90-day supply.

Mail Order Pharmacy

We use Alliance Rx Walgreens Pharmacy as our mail-order pharmacy. You must register and have your prescriptions sent to Alliance Rx Walgreens Pharmacy. Most maintenance medications can be filled for up to a 90-day supply.

Alliance Rx Walgreens Pharmacy
P.O. Box 29061
Phoenix, AZ 85038-9061

Alliance Rx Walgreens Pharmacy
Customer Care Center
Phone: **1-800-345-1985**
Fax: **1-480-752-8250**
https://www.alliancerxwp.com/

Specialty drug program
We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions and are staffed with clinicians to provide support services for members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-Day supply of medication at one time, and the supply is delivered via mail to either the member's home or your doctor's office in certain cases. This is NOT part of the mail-order pharmacy Benefit. Extended-Day supplies and Copayment savings do not apply to these designated specialty drugs.

COVID-19
Covid-19 Vaccines: FDA approved Covid-19 vaccines are covered at $0 copay according to FDA approved indications and age.

For details on the latest formulary information on COVID-19 vaccines, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-844-211-0968 (TTY 711)**.

School Supply

AmeriHealth Caritas North Carolina Exchange allows school supplies for the following medications:

- Insulin
- Insulin needles
- Lancets
- Test strips
- One glucometer for school
- Alcohol swabs
- Glucagon
- Inhalers
- Diastat
- EpiPens
- Spacers

For our latest pharmacy benefit and formulary information, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-844-211-0968** (**TTY 711**).

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 at. If you have a medical condition or health factor that makes it difficult to complete any of the program's activities, you may still receive your reward by requesting a waiver. The waiver will require you to provide a note from your physician, advising us that you are unable to complete the specified activity due to a medical condition or health factor. You may contact the Member Services phone number on the back of your member ID card for additional information about the waiver process. 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.

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 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.

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 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, personality disorders, factitious disorders, sleep disorders, 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., 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 services not identified as a covered health service under this policy; you will be responsible for payment in full for any services that are not covered health services.
- Expenses, fees, taxes, or surcharges imposed by a provider or facility that are actually the responsibility of the provider or facility.
- Any covered health service, supply, or device that would otherwise be at no cost in the absence of coverage by this policy.
- Any experimental or investigational treatments or unproven services.
- Treatment received outside the United States, except for a medical emergency while traveling in accordance with the emergency services section of this policy.
- Any medical and/or recreational use of cannabis or marijuana.
- Birthing services provided by a Doula
- Incontinence supplies
- Refractive laser eye surgery such as laser-assisted in situ keratomileusis (LASIK)
- Safety glasses, athletic glasses, and sunglasses; non-standard lenses such as photocolor or scratch resistant lenses
- Gender affirming care

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

- Services or supplies are provided prior to the effective date or after the termination date of this policy, except as noted under the eligibility and termination section of this policy.
- For the reversal of sterilization or vasectomies.
- For abortion, unless necessary to save the life or health of the member, or as a result of incest or rape.
- For fetal reduction surgery.
- For expenses related to television, phone, or expenses for other persons.
- For standby availability of a medical provider when no treatment is rendered.
- For dental services. We will inform members of the availabilities of stand-alone pediatric dental plans during the plan selection and enrollment process.
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this policy or for correction of a birth defect in a child.
- For behavioral health services related to:
    - Testing for evaluation and diagnosis of learning abilities.
    - Premarital counseling.
    - Non-medically necessary court-ordered services required for parole or probation.
    - Testing for aptitude or intelligence.
- For employment-related diagnostic testing, laboratory procedures, screenings, or examinations.
- For services related to surrogate parenting.
- For nontraditional alternative or complementary medicine not consistent with conventional medicine. These include, but are not limited to, acupuncture; hydrotherapy; hypnotism; and alternative treatment modalities including, but not limited to, boot camp, equine therapy, wilderness therapy, and similar programs.
- For treatment of injuries sustained while participating in organized collegiate sports, professional or semiprofessional sports, or other recreational activities for which the subscriber and/or dependent is paid to participate.
- For immunization or exam services required for foreign travel or employment purposes

GRIEVANCES AND APPEALS

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

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

Grievances

You, your authorized representative, or your provider can file a grievance with us at any time and can do so in writing or over the phone. If the provider files a grievance on behalf of the member and we do not have record of the members' consent; the grievance team will need to secure the members consent for the grievance. The **Grievance** process is voluntary, and our process provides for both first and second-level grievance reviews. If you need help with filing a **grievance**, we will help walk you through the process, including providing help with completing forms, providing interpreter and translation services, or providing TTY support.

Grievance procedure — First-level review

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

Member Grievances

PO Box 7430

London, KY 40742-7430

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

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

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

After we research your concern, we will send you and, if applicable, your authorized representative a written notice on how your concern has been resolved. In most instances, we will provide you with this written notice within 30 calendar days of receiving your grievance. On rare occasions, you or we may ask for an additional 14 calendar days for resolution, especially if more information is needed that would be helpful to resolving your grievance. We will notify you verbally of any extension and send you written notice within two calendar days explaining the reason for the extension.

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

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

Grievance procedure — second-level review

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

Member Grievances

PO Box 7430

London, KY 40742-7430

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

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

Your grievance will be reviewed by the review panel. The review panel will schedule a review meeting within 45 days after receiving your request for a second-level review. We will notify you

of the date of the review meeting, in writing, at least 15 days before the meeting takes place. Your right to a full review will not be conditioned on attendance of the review meeting.

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

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

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

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

Grievance procedure — expedited review

If your grievance regards a decision or action on our part that could significantly increase risk to your life, health, or ability to regain maximum function, please call Member Services immediately to file an expedited grievance.

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

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

When you are eligible for an expedited second-level review, we will conduct the review proceeding and communicate the decision to you, your authorized representative, or provider who initiated the request no later than four days after receiving the information justifying expedited review. The review meeting may take place by way of a phone conference call or through the exchange of written information.

Standard appeals

You, your authorized representative, including your provider can file an appeal of an Adverse Benefit Determination verbally by calling Member Services at 1-833-613-2262 or in writing to PO Box 7417, London, KY 40742-7417. We must receive a signed authorized representative form in order to process an appeal from your provider. An appeal must be filed within 180 days from the date of our written notice denying your claim or your request for service. The appeal procedure is voluntary on the part of the member and an appeal may be initiated and/or proposed by the member or a person acting on behalf of the insured such as a relative or other representative, including his/her provider.

Verbal appeals: The date you make your verbal appeal counts as the date of receipt of your appeal.

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

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

You may be financially responsible for the continued services if the appeal is not approved. You can request continued services by calling Member Services at 1-833-613-2262 (TTY 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. An expedited appeal will be made available when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person’s ability to regain maximum function. Your provider can also file a verbal request for expedited appeal. We

will not require written follow-up for a verbal request for expedited appeal. We may require documentation of the medical justification for an expedited appeal.

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

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

You will have the opportunity to provide evidence in support of your appeal by phone, in writing, or in person.

We will, in consultation with a medical doctor licensed to practice medicine in North Carolina, provide expedited review and communicate the decision to you, your authorized representative, or provider who initiated the request verbally within 72 hours after receipt of the expedited review request, and in writing as soon as possible. If the expedited review is a concurrent review determination, we will remain liable for the coverage of health care services until the covered person has been notified of the determination. We are not required to provide an expedited review for retrospective noncertifications.

Independent External Review

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

- receive a noncertification decision
- receive an appeal decision upholding a noncertification decision

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax) 866-582-2053

In Person:
NC Department of Insurance

3200 Beechleaf Court
Raleigh, NC 27604
1-855-408-1212 (toll-free)

Smart NC for External Review information and Request Form

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

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

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

CLAIMS AND REIMBURSEMENT

Claims

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

Network provider claims

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

Out-of-network provider claims

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

To give notice of a claim, please call us at the phone number listed on your member ID card to obtain a claim form. You must sign the claim form before we will issue payment to a provider or reimburse you for covered services received under this policy. You must complete a claim form for services rendered by an out-of-network provider and submit it, together with an itemized bill and proof of payment, to AmeriHealth Caritas Next, PO Box 7411, London, KY 40742-7411.

Reimbursement

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

Claim forms

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

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

Time of payment of claims

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

Payment of claims

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

Unpaid premium

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

MEMBER RIGHTS AND RESPONSIBILITIES

Member rights

A member has the right to:

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

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

Member responsibilities

A member has the responsibility to:

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

GENERAL PROVISIONS

Entire policy

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

Modifications

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

Non-waiver

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

Conformity with state laws

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

Nondiscrimination

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

Continuation of benefit limitations

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

Protected health information (PHI)

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

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

Our relationship with providers

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

APPENDIX A – COORDINATION OF BENEFITS

Coordination of this Contract's Benefits with Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

A. **Plan** - A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** – This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health

care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** – an Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement

methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** – A Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent –** A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan

B.

1. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this

supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    a) For a dependent child, whose parents are married or are living together, whether or not they have ever been married:
        - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
        - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
    b) For a dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (1) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (1) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or

laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan.

   If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the benefits of this plan

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In

addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. AmeriHealth Caritas Next may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. AmeriHealth Caritas Next need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give AmeriHealth Caritas Next any facts it needs to apply those rules and determine benefits payable.

Facility of payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, AmeriHealth Caritas Next may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. AmeriHealth Caritas Next will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right to recovery

If the amount of the payments made by AmeriHealth Caritas Next is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

APPENDIX B – COORDINATION OF BENEFITS SUMMARY

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all the coordination rules and procedures and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of Benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This plan is primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and

- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or

- You are separated or divorced, and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

- There is no court decree, but you have custody of the child.

Other Situations

- We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part, or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance, and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.

- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the

total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

HOW TO CONTACT US

Method	Member Services — contact information
CALL	1-833-613-2262 Calls to this number are free. Hours of operation: 8 a.m. to 6 p.m., Monday to Friday, excluding holidays
TTY	711 Calls to this number are free.
FAX	1-844-201-6792
WRITE	Mailing address: PO Box 7410 London, KY 40742-7410
WEBSITE	https://www.amerihealthcaritasnext.com/about/contact.aspx

AmeriHealth Caritas Next

A product of AmeriHealth Caritas North Carolina, Inc.

Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; or sex, including sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes [consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)]. AmeriHealth Caritas Next does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. AmeriHealth Caritas Next provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats. If you need these services, contact the Member Services number on the back of your card. If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way, you can file a grievance with AmeriHealth Caritas Next, Attention: Appeals and Grievances, P.O. Box 7430, London, KY 40742-7430 fax: **1-844-201-6798,** or email **acaexchangegrievance@amerihealthcaritas.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby. jsf,** or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201, phone: **800-368-1019**, TTY: **1-800-537-7697**, Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**.

We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

Chúng tôi cung cấp thông tin và các dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh. Để nói chuyện với thông dịch viên, hãy gọi đến số điện thoại của Dịch Vụ Hội Viên ở mặt sau thẻ của quý vị.

영어가 주 언어가 아닌 사람들을 위해 무료로 언어 서비스와 정보를 제공합니다. 통역사와 대화하려면 가입자 카드 뒷면에 기재된 가입자 서비스 번호로 연락하십시오.

نقدم خدمات ترجمة مجانية ومعلومات للأشخاص الذين لغتهم الأساسية ليست اللغة الإنجليزية. للتحدث مع مترجم، اتصل برقم خدمات الأعضاء الموجود على ظهر بطاقتك.

Peb muab kev pab cuam txhais lus pub dawb thiab cov ntaub ntawv rau cov neeg uas hom lus ib txwm hais tsis yog lus Askiv. Txhawm rau txuas lus nrog ib tus kws pab txhais lus, hu rau tus npawb xov tooj Pab Cuam Tswv Cuab nyob sab tom qab ntawm koj daim npav.

Мы предоставляем бесплатные языковые услуги и информацию людям, для которых английский не является родным. Чтобы обратиться к переводчику, позвоните по номеру, указанному на обратной стороне вашего удостоверения.

Nagkakaloob kami ng mga libreng serbisyo sa wika at impormasyon sa mga indibidwal na ang pangunahing wika ay hindi Ingles. Upang makipag-usap sa isang interpreter, tumawag sa numero ng Member Services sa likod ng iyong card.

અમે એવા લોકોને નિ:શુલ્ક ભાષા સેવાઓ અને માહિતી પ્રદાન કરીએ છીએ જેમની પ્રાથમિક ભાષા અંગ્રેજી નથી. દુભાષિયા સાથે વાત કરવા માટે, તમારા કાર્ડની પાછળ આપેલ સભ્ય સેવા નંબર પર કૉલ કરો.

We speak your language

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

យើងផ្តល់ជូនសេវាកម្មភាសា និងព័ត៌មានដោយឥតគិតថ្លៃទៅដល់អ្នកដែលមានភាសាទីមួយមិនមែនជាភាសាអង់គ្លេស ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ សូមហៅទៅលេខទូរស័ព្ទរបស់សេវាកម្មសមាជិកនៅខាងខ្នងនៃប័ណ្ណរបស់អ្នក ។

Wir bieten Menschen, deren Muttersprache nicht Englisch ist, kostenlose Sprachdienste und Informationen an. Wenn Sie mit einem Dolmetscher oder einer Dolmetscherin sprechen möchten, rufen Sie bitte die Nummer des Mitgliederservice auf der Rückseite Ihrer Karte an.

हम उन लोगों को मुफ्त भाषा सेवाएं और जानकारी प्रदान करते हैं जिनकी प्राथमिक भाषा अंग्रेजी नहीं है। दुभाषिए से बात करने के लिए, अपने कार्ड के पीछे सदस्य सेवाओं के नंबर पर कॉल करें।

ພວກເຮົາໃຫ້ບໍລິການພາສາຟຣີແລະຂໍ້ມູນຂ່າວສານສໍາລັບຜູ້ທີ່ພາສາຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາເບີບໍລິການສະມາຊິກຢູ່ດ້ານຫຼັງບັດຂອງທ່ານ.

英語を母国語としない人々に、無料の言語サービスと情報を提供しています。通訳者と話すには、カード裏面に記載されているメンバーサービス番号に電話してください。