Provider Manual

Effective Date: April 1, 2024

This Provider Manual is subject to change.
Changes based on state or federal requirements may be made at any time. This document applies to AmeriHealth Caritas Next individual and family health insurance products both on and off the exchange.

AmeriHealth Caritas℠ Next

A product of AmeriHealth Caritas Florida, Inc.

www.amerihealthcaritasnext.com

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Welcome

Welcome to AmeriHealth Caritas Next, the AmeriHealth Caritas Florida, Inc. HMO Benefit Program offered both on and off on the Health Insurance Marketplace®. AmeriHealth Caritas Next offers affordable health plans for eligible individuals or families who do not have coverage through their employer, and do not qualify for Medicare or Medicaid.

Participating on the Exchange aligns with our vision to empower those in need across their full life journey, by providing a health insurance option for those who otherwise would have no access to health insurance coverage. It allows you, the Provider, to continue to work with our Members under a commercial reimbursement arrangement, if they are no longer eligible for our Medicaid plan, AmeriHealth Caritas Florida.

Thank you for your participation in the AmeriHealth Caritas Next Provider network. We look forward to working with you!

General Information

The *Provider Manual* is part of your Provider Agreement, with AmeriHealth Caritas Florida, Inc. for AmeriHealth Caritas Next *(*referred to as AmeriHealth Caritas Next or "the Plan" throughout this manual). This manual supplements the terms of your contract and is updated regularly to provide you with pertinent policies, procedures, and administrative functions relevant to the daily administration of your practice when providing Covered Services to AmeriHealth Caritas Next Members.

This *Provider Manual* was created to assist you and your office staff with providing services to our Members, your patients. As a Provider, you agree to use this *Provider Manual* as a reference pertaining to the provision of medical services for Members of the Plan.

This *Provider Manual* may be changed or updated periodically. The Plan will provide you with notice of updates; Providers are also responsible to check the Plan's website, https://www.amerihealthcaritasnext.com/fl regularly for updates.

The *Provider Manual* is one of several communication vehicles that enables us to offer timely, pertinent information to you. We will provide you with regular updates through the following resources:

- Website: https://www.amerihealthcaritasnext.com/fl
- The NaviNet®® web portal: An online, no cost to Providers' gateway that allows real-time transactions between The Plan and its Providers.
- Provider Notices sent via fax and/or permission-based e-mail.

Contact Information

Corporate Office	
AmeriHealth Caritas Corporate Office 3875 West Chester Pike Newtown Square, PA 19073 1-215-937-8000	
Members	**Providers**
AmeriHealth Caritas Next 200 Stevens Drive Philadelphia, PA 19113 1-833-999-3567 TTY 711	AmeriHealth Caritas Next 11631 Kew Gardens Ave., Suite 200 Palm Beach Gardens, FL 33410 1-833-983-3577

Department	Phone	Fax/Email /Web address
Provider Services Monday through Friday, 8 a.m. to 8 p.m. ET	1-833-983-3577	1-833-329-3577
Member Services Monday through Friday, 8 a.m. to 8 p.m. ET	1-833-999-3567 (TTY) 711	1-833-329-3567

Medical Management		
Department	**Phone**	**Fax/Email /Web Address**
Florida Behavioral Health Crisis Line	1-800-273-TALK	
Rapid Response and Outreach Team (RROT)	1-833-435-7708	1-833-770-8329
Bright Start® Maternity Program	1-833-435-7708	1-833-770-8329

Care Management and Care Coordination	1-833-435-8600	1-833-435-3290
Hospital Admittance, discharge and concurrent review		1-833-999-3567
Utilization Management		
Department	**Phone**	**Fax/Email /Web Address**
Physical Health	1-833-435-8600	1-833-435-3290
Behavioral Health	1-833-435-8600	1-833-329-3529
Peer to Peer	1-833-727-0990	
Evolent		
Evolent Prior Authorization	800-327-1187	***www.radmd.com***
Credentialing		
Department	**Phone**	**Fax/Email /Web Address**
Credentialing and Recredentialing	1-833-983-3577	
Pharmacy		
Department	**Phone**	**Fax/Email /Web Address**
PerformRx Member Services	1-833-981-7967	
PerformRx Provider Services	1-833-982-7977	
Prior Authorization	1-833-982-7977	- 1-844-470-2507
Program Integrity		
Department	**Phone**	**Fax/Email /Web Address**
To report suspected fraud, waste, and abuse	1-866-833-9718	
Member Appeals		

Member Appeals	1-833-999-3567 (TTY) 711	1-833-435-2967
Provider appeals on behalf of a Member	1-833-999-3567 (TTY) 711	1-833-983-3529
NaviNet® (Secure Provider Portal)		
Department	**Phone**	**Fax/Email /Web Address**
NaviNet®	1-888-482-8057	NaviNet®.navimedix.com
Change Healthcare (Clearinghouse)		
Department	**Phone**	**Fax/Email /Web Address**
Electronic Claims Submission (Connect Center)	1-800-527-8133, option 2	https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214629
Change Healthcare/Echo Health Inc.		
Electronic Payment Options Virtual Credit Card (VCC) Electronic Funds Transfer (EFT) and MedPay (from Change Healthcare/Echo, Inc.)	1-888-492-5579, option 2 Change Healthcare Payer ID 45408 ECHO Payer ID 58379	
EDI Support		
EDI Technical Support	1-833-983-3577	AHCNext@amerihealthcaritas.com

Account Executives

Account Executives play a critical role in educating our network Providers and their office staff on policies, procedures, and specific billing processes. Account Executives also serve as a liaison for the Provider's office and may promote or suggest workflow solutions.

In an effort to build and sustain a strong working relationship with Participating Providers, Account Executives will:

- Communicate with Primary Care Physician (PCP) offices and specialists on a regular basis to help resolve issues, review medical and claims payment policies, discuss new policy implementation, review utilization reports, recommend sources for more efficient utilization, and explain new products and programs.
- Investigate and assist in providing resolution to Provider inquiries.
- Assist with policy and procedural issues that your office experiences and recommend potential resolutions.
- Conduct initial orientation with your staff about the Plan.
- Explain procedures for requesting claims adjustments or initiating claim dispute.

Note: Account Executives cannot revise claims submissions.

We encourage you to utilize the self-service tools available through the NaviNet® web portal, including verification of Member eligibility, claim status, and claim inquiry submission.

Account Executives serve multiple Provider offices in the network. All inquiries regarding your office are important to us. Your Account Executives will address your questions in as timely a manner as possible.

If you need to identify who your Account Executive is, please call Provider Services at 1-833-983-3577 or visit https://www.amerihealthcaritas.com/fl.

Provider Services

Our Provider Services department serves as a valuable resource to you, in addition to your Account Executive. The role of Provider Services is to:

- Address Provider telephone inquiries in an accurate and timely manner.
- Educate Providers and facilitate effective communication between Providers and the Plan by responding to telephone inquiries in a timely and accurate way.
- Educate Providers about self-service utilization.
- Assist Providers with claim inquiries.

To reach Provider Services, call 1-833-983-3577.

Provider Communications

To access the most current and updated information regarding the Plan and our policies, procedures, and processes, refer to our Provider web page at https://www.amerihealthcaritasnext.com/fl, NaviNet® Plan Central, and this *Provider Manual*. These resources are designed to work in conjunction with each other to provide your office with timely informational updates.

The Plan will not use a Provider's name or image without the Provider's written consent.

Provider Website

Our Provider-dedicated web pages can be found at https://www.amerihealthcaritasnext.com/fl featuring up-to-date news and information of interest to Providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office. Additionally, you can easily access resources including forms, NaviNet®, and Provider publications.

NaviNet® Provider Portal

NaviNet® is an easy-to-use, no-cost to Providers, secure portal that links Providers to the Plan Members. Our secure Provider portal (https://www.navinet.net) offers web-based solutions that allow Providers and health plans to share critical administrative, financial, and clinical data in one place. This tool can help you manage patient care with quick access to:

- Member eligibility and benefits information, including Member in pending status.
- Panel roster reports.
- Care gap reports to identify needed services.
- Member clinical summaries.
- Social determinants of health information.
- Admission and discharge reports.
- Medical and pharmacy claims data.
- Electronic submission of prior authorization requests.

If you do not already use NaviNet® to keep you informed of your Member accounts, go to https://www.NaviNet®.net to register. All you need is a Federal Tax ID.

Self-Service Requirements

All Participating Providers, facilities, and billing agencies that support Provider organizations are encouraged to have NaviNet® access and complete the tasks listed below using NaviNet®.

- Eligibility and claims status. All Participating Providers and facilities are required to use NaviNet® to verify Member eligibility and obtain Plan claims status information. The claim detail provided through NaviNet® includes specific information, such as check date, check number, service codes, paid amount, and Member responsibility.
- Authorizations.* All Participating Providers and facilities should use NaviNet® to initiate the following authorization types: Medical/surgical procedures, chemotherapy/infusion therapy, durable medical equipment (DME), emergency hospital admission notification, home health (dietitian, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, behavioral health inpatient admission, substance use disorder inpatient rehabilitation, and electroconvulsive therapy.
- Requests for medical/surgical procedures can be made up to six months in advance on NaviNet®. In some cases, requests for Medically Necessary care are authorized immediately; however, some

authorization requests may result in a pended status (e.g., when additional clinical information is needed or when requests may result in a duplication of services). NaviNet® submissions that result in a pended status can vary in the time it takes for completion. If an urgent request (i.e., procedure or admission for the same or next day) results in a pended status, please call 1-833-435-8600 for assistance.

*Note: If the authorization is in a pended status, it is not yet approved. Providers should not submit any claims or claim inquiry requests that relate to the pended authorization until it has an approved status of "certified." If claims are submitted prior to the authorization being approved, they may be rejected.

- Claims investigation inquiry. Providers may question a claim payment or request a claim adjustment by submitting the request via NaviNet® using the Claim Investigation Inquiry transaction. Requests can be submitted for dates of service up to 365 days prior to the current date of service.

NaviNet® Security Officer

The NaviNet® Security Officer is your office's primary contact with NaviNet® regarding security issues with the portal. NaviNet®-enabled offices must designate at least one NaviNet® Security Officer. The Security Officer also interacts with NaviNet® users in your office and with NaviNet® Customer Support to ensure that users are getting the most out of NaviNet®. HIPAA mandates that each Provider office designate a Security Officer to be aware of the electronic storage and transmission of patient information within and from your office. This person can also take the role of the NaviNet® Security Officer.

Roles and responsibilities of the Security officer

A NaviNet® Security Officer is responsible for making sure that NaviNet® is used in a HIPAA-compliant way. He or she is also responsible for configuring Providers, users, and permissions so the office can use NaviNet® effectively as well as efficiently.

For more detailed information on common Security Officer tasks, as well as best practices, please visit the Security Officers page on NaviNet®.

NaviNet® Resources

Detailed guides, frequently asked questions, and training resources are available to all users for many transactions on NaviNet® from the NaviNet® Basics page. If you are a current NaviNet® user and need technical assistance, contact NaviNet® at 1-888-482-8057. If you are not yet NaviNet®-enabled, go to https://www.NaviNet®.net to sign up.

For Expedited Registration: **A Federal Tax ID and a recently submitted claim (within the last 90 days).**

NaviNet® will use the details of the claim to authenticate your office. If you do not have a claim handy, you may still register, but the process will take longer.

If you need assistance, call NaviNet® Customer Services 1-888-482-8057. Customer care hours are weekdays from 8am to 11pm EST and Saturdays from 8am to 3pm EST.

NaviNet® Plan Central Page

In addition to fast, secure, and HIPAA-compliant access to Provider and Member information and real-time transactions, NaviNet® gives Providers access to a valuable source of information on our NaviNet® Plan Central page. This page contains important tools and resources, including:

- The latest Provider news and announcements.
- The most current version of our publications and *Provider manuals*.
- Links to NaviNet® Resources.
- Contact information.

Through NaviNet® you can access:

- Member eligibility verification.
- Claims submission and status.
- Claims investigation.
- Prior authorization submission.
- Care gap reports to identify needed services.
- Member Clinical Summaries.
- Member panel rosters for PCPs in your practice.

Privacy and Confidentiality

Provider Obligations

AmeriHealth Caritas Next complies with all federal and Florida laws and regulations regarding Member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information as outlined in 45 CFR Parts 160 & 164. All Member health and enrollment information is used, disseminated, and stored according to Plan policies and guidelines to ensure its security, confidentiality and proper use. As a network Provider, you are expected to be familiar with your responsibilities under HIPAA which governs the confidentiality of alcohol and drug treatment information, and to take all necessary actions to fully comply.

Contracted Providers are required to maintain the confidentiality of Member protected health information (PHI), in electronic, written and oral forms, in accordance with applicable state and federal laws.

AmeriHealth Caritas Next Providers are required to assist with privacy and security investigations, including providing attestations of destruction in a timely manner, in order to ensure that contractual requirements are met.

Access to PHI

The Health Insurance Portability and Accountability Act (HIPAA), and its implementing regulations, permit a HIPAA-Covered Entity, such as AmeriHealth Caritas Next, to request and obtain our Members' PHI from third

parties. An example of a "third party" would be a HIPAA-Covered Entity such as a health care Provider. When such PHI is requested for purposes of treatment, payment, and/or health care operations, the Member's authorization is not required. HIPAA specifically permits health care Providers to disclose PHI, including Members' medical records to health plans for treatment, payment, or health care operations. AmeriHealth Caritas Next uses this information to promote Members' ready access to treatment and the efficient payment of Members' claims for health care services.

Other AmeriHealth Caritas Next activities that can be categorized as "treatment, payment, or health care operations" under HIPAA include, but are not limited to, the following:

- Treatment includes the provision, coordination, and management of the treatment. It also includes consultation and the referral of a Member between and among health care Providers.
- Payment includes review of various activities of health care Providers for payment or reimbursement; to fulfill the health benefit plan's coverage responsibilities and provide appropriate benefits; and to obtain or provide reimbursement for health care services delivered to its Members. Activities that fall into this category include but are not limited to determination of Member eligibility, reviewing health care services for Medical Necessity, and utilization review.

Health care operations include certain quality improvement activities, such as case management and care coordination, quality of care reviews in response to Member or State/federal queries, and prompt response to Member complaints/grievances; site visits; medical record reviews to conduct clinical and service studies to measure compliance; administrative and financial operations, such as conducting Healthcare Effectiveness Data and Information Set (HEDIS®) reviews and Customer Service activities; and legal activities, such as audit programs, including fraud and abuse detection, and to assess Providers' conformance with compliance programs.

Privacy Policies

Protecting the privacy of our Members' information is very important to us. That is why we have taken numerous steps to see that our Members' PHI, whether in oral, written, or electronic form, is kept confidential.

We have implemented policies and procedures regarding the collection, use, and disclosure of PHI by and within our organization and with our business associates. We continually review our policies and monitor our business processes to ensure that Member information is protected, while continuing to make the information available as needed for the provision of health care services. For example, our procedures include processes designed to verify the identity of someone calling to request PHI, procedures to limit who on our staff has access to PHI, and policies that require us to share only the minimum necessary amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks or by using encryption technology when the information is sent by e-mail.

We do not use or disclose PHI without the Member's written authorization unless we are required or permitted to do so by law. If use or disclosure of a Member's PHI is sought for purposes that are not specifically required or permitted by law, the Member's written authorization is required. To be deemed valid, Member authorizations must include certain elements required by State and/or federal law.

Members may print a copy of our Authorization for Sharing Health Information form from our website or request a copy by calling Member Services at 1-833-999-3567.

For more detailed information about our Members' privacy rights and how we may use and disclose PHI, review our Notice of Privacy Practices, which is available on our website https://www.amerihealthcaritasnext.com/fl.

Administrative Procedures

Rendering Services

Be sure to verify Member eligibility and cost-sharing amounts (i.e., copayments, coinsurance, and deductibles) each time a Member is seen.

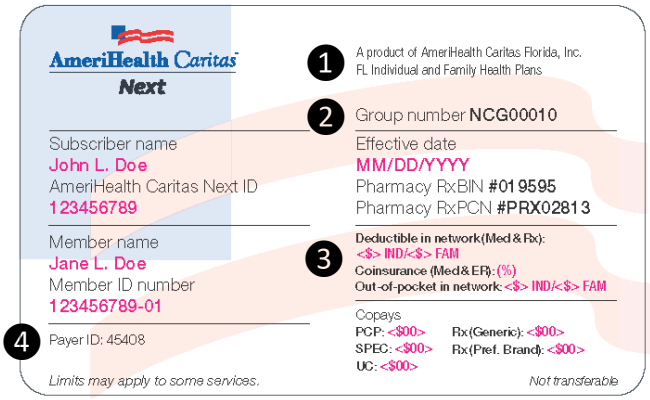
Member ID Card

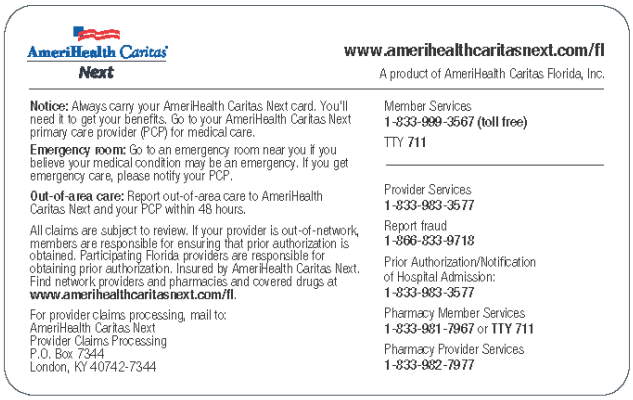
AmeriHealth Caritas Florida, Inc. offers three different products in Florida. **AmeriHealth Caritas Next** AmeriHealth Caritas Next offers affordable health plans for eligible individuals or families who do not have coverage through their employer and do not qualify for Medicare or Medicaid.

AmeriHealth Caritas Florida
AmeriHealth Caritas Florida was selected by Florida to be one of the Medicaid managed care plans for the Florida programs.

AmeriHealth Caritas VIP Care (Dual Eligibility Special Needs Program)
AmeriHealth Caritas VIP Care is a Medicare Advantage D-SNP plan for those beneficiaries who are dually eligible for both Medicare and Medicaid. Florida will offer extra benefits and support to assist our dual-eligible Members in accessing their Parts A, B, and D benefits that are normally provided under traditional Medicare. Our approach integrates proven, established care management, preventive services, and other programs that effectively coordinate care for aged, blind, and disabled individuals.

There are a number of differences between the two ID cards. Below are some identifiers that are contained in the AmeriHealth Caritas Next ID cards:





1. The legal tagline for AmeriHealth Caritas Florida, Inc. is written on the upper right-hand corner but does not appear on the AmeriHealth Caritas Florida Medicaid card.
2. In the "Group Number" field on the AmeriHealth Caritas Next Member ID card, the Group Number represents the specific product selected by the Member and starts with initials NCG (Gold), NCS (Silver) or NCB (Bronze).
3. The AmeriHealth Caritas Next Member ID card has copayments, deductibles and has a subscriber and Member name, whereas the AmeriHealth Caritas Florida Medicaid card has only a Member name.
4. The Payer ID is displayed on the front of the card.

How to Verify Member Eligibility

Member ID cards carry important information, such as name, ID number, prefix, and coverage type. If you use a Member's ID card to verify information, please keep in mind that the information displayed on the card may vary based on the Member's plan. Eligibility is not a guarantee of payment. In some instances, the Member's coverage may have been terminated.

- Always check the Member's ID card before providing service. If a Member is unable to produce his or her ID card and/or is not listed on the Primary Care Physician's (PCP) roster, ask the Member for a copy of his or temporary insurance information printed from the Members section of https://www.amerihealthcaritasnext.com/fl, our secure Member website. This form is issued to Members as temporary identification until the actual ID card is received and may be accepted as proof of coverage. The temporary ID card is valid for a maximum of ten calendar days from the print date.
- Participating Providers should use the NaviNet®® web portal for all Member eligibility inquiries. There are occasions when a Member's health insurance may be effective before his or her ID card is received in the mail. In this situation, you can still verify the Member's eligibility by using the Eligibility and Benefits Inquiry transaction on NaviNet® and selecting the "Patient Name/Patient Date of Birth" search type.

In the event that there is a question about the Member's eligibility or panel assignment, check NaviNet®.

Providers are responsible for checking the Member's eligibility status prior to rendering services. Members in good standing can be confirmed in the Eligibility and Benefits Inquiry section of NaviNet®, which can be accessed from the left-hand navigation of the Plan Central page.

Below are the Provider portal delinquent status messages that will be displayed based on Plan Member eligibility status:

Member category	Delinquent period	Provider portal delinquent status message
APTC	First month	Active
	Second month to end of third month	Delinquent Member — All claims will be pended until outstanding premium payment is received. Claims will be rejected if payment is not received by the end of the grace period.
	After third month	Inactive
Non-APTC	Days 1 – 31	Suspended (claims pend)
	After 31 days	Inactive

If we are unable to verify eligibility, the Plan will not be responsible for payment of any emergency or non-emergency services.

Copayments

Members are responsible for making all applicable copayments. The copayment amounts vary according to the Member's type of coverage and benefits plan. In addition, please note the following:

Copayment verification:

- Copayments can be found by selecting the various links at the bottom of the Eligibility and Benefits Details screen when using the Eligibility and Benefits Inquiry transaction in NaviNet®.
- Radiology, physical therapy, and occupational therapy services may be subject to copayment amounts that differ from the specialist copayment amount identified on the Member's ID card. Copayments for these services should be verified using the Eligibility and Benefits Inquiry on NaviNet®.

Collecting Copayments:

- Copayments may not be waived and should be collected at the time services are rendered. If a Member is unable to pay the copayment at the time services are rendered and has been provided with prior notice of this requirement, Providers may bill the Member for the copayment.
- A Provider must notify a Member if the office provides services where the Member may be billed by more than one Provider. For example, the office must inform the Member when he or she will be charged a copayment for a Physician service and a copayment for an ancillary service, such as radiology. If two services are billed on the same date of service, two copayments may be required.
- PCPs may not charge a Member for a copayment unless the Member is seen by a Provider. No copayment is to be charged or collected by the PCP if a Member is only picking up a copy of a referral or prescription from the office.
- If the Member's specified copayment is greater than the allowable amount for the service, only the allowable amount should be collected from the Member. However, if the allowable amount for the service is greater than the copayment, the specified copayment should be collected in full from the Member. In the event that a copayment is collected and the practice subsequently determines that the allowable amount is less than the copayment, the difference between the copayment and the allowable amount must be refunded to the Member within a reasonable period of time at no charge/cost to the Member.
- Members can receive a colon cancer preventive screening colonoscopy with no Member cost-sharing ($0) when the service is performed at a freestanding Ambulatory Surgery Center (ASC). Providers should assist with referring Members to a freestanding ASC and associated gastroenterologist and colon and rectal surgeon in order for the Members to take advantage of the $0 cost-sharing. Providers can use the Provider Directory to identify locations.
- Plan Health Care Reform requirements. The following copayment rules are required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform):
    - There is no Member cost-sharing (i.e., $0 Copayment) for preventive services identified under the Affordable Care Act and provided to Members by a network Provider. A complete list of preventive services with $0 Member cost sharing can be found on the CMS website https://www.healthcare.gov/coverage/preventive-care-benefits/.

Note: The $0 copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a copayment. However, if the Member is experiencing a significant problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for application of a copayment.

Note: Health Care Reform regulations require an "embedded" in-network out-of-pocket maximum for each individual to limit the amount of out-of-pocket expenses that any one person will incur. This means that each Member enrolled in an individual plan, or any person in a family plan, will only pay the in-network out-of-pocket maximum set for an individual and not be required to pay out of pocket to meet the family in-network out-of-pocket maximum for the plan.

For a family plan, after one person meets the individual in-network out-of-pocket maximum for their plan, the other family Members continue to pay out of pocket until the remaining family in-network out-of-pocket maximum amount is met.

The Plan routinely audits the claims we adjudicate to ensure they are paid accurately and in accordance with the Member's benefit plan. Audits include, but are not limited to, ensuring appropriate application of cost-sharing.

Telemedicine

Telemedicine services through AmeriHealth Caritas Next Telemedicine's vendor are covered at $0 cost share. Certain specialty services including pediatrics are not eligible for AmeriHealth Caritas Next Telemedicine. Telemedicine services from any other professional Provider are covered, subject to the same cost sharing and out of network limitations as the same health care services when delivered to a Member in-person. This includes encounters for Members seeking primary care services from PCPs (family medicine, internal medicine, general medicine, and pediatric medicine) who offer telemedicine services as an additional method of delivery. These encounters allow our Members to interact with PCPs using a Health Insurance Portability and Accountability Act (HIPAA)-secure audio/visual system that allows Members and Providers to see and hear one another in real time.

Benefits include:

- Gives PCPs the ability to communicate with their patients in the event that an in-person encounter is not possible.
- Provides a more cost-effective option than visiting an ER, retail health clinic, or urgent care center for non-emergency medical conditions.
- Offers care after normal business hours, including nights, weekends, and even holidays (availability may vary).

When billing telemedicine services, Providers must use the appropriate modifier to identify the service was provided via telemedicine. For additional telemedicine requirements, visit the Board of Medicine website at https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine.

Grace Period for Delinquent Members

90-day grace period for Advanced Premium Tax Credit (APTC) Members

The Patient Protection and Affordable Care Act (PPACA) requires a three-month grace period for Members who receive the Advanced Premium Tax Credit (APTC) and are delinquent in paying their portion of their health insurance premiums before the Member's health insurance can be terminated. Please note that Members must first pay their initial premium payment to be eligible for the grace period.

On-Marketplace Members who receive APTC:

- 3-month grace period.
- The Plan will pay claims for the 1st month of the grace period.

- Claims will be pended for the 2nd and 3rd month of the grace period.
- If the Member pays their outstanding balance before the end of the 3rd month, the Plan will process and adjudicate pended claims.
- If the Member does not pay their outstanding balance before the end of the 3rd month, the Plan will terminate coverage as of the last day of the first month of grace period and deny all pended claims.

For Pharmacy claims, claims are paid for the first month (30 days) and denied beginning day 31 and thereafter.

Off-Exchange Members or On-Exchange Members who DO NOT receive APTCs:

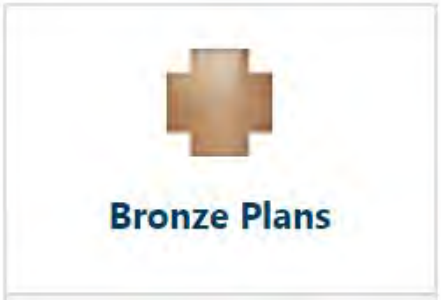
- 31-day grace period
- Claims will be paid for the full grace period.
- If a Member does not pay their outstanding balance before the end of the 31-day grace period, then we will terminate coverage as of the last day of the grace period
- If a Member has lost coverage due to non-payment, and the Provider provides services, the Plan will deny claims submitted for those services.

For Pharmacy claims, claims are paid for the first month (31 days) and denied beginning day 32 and thereafter.

To identify when a Member is in a delinquent payment status on their monthly insurance premiums, please go to the Eligibility and Benefits Details screen on NaviNet®.

Plan Overview

The Plan offers six standard plans on and off the Florida Health Insurance Marketplace® with varying cost-sharing and deductibles based upon their plan.



- The plan with the lowest monthly premium. This plan will work best if you think you will not need a lot of health care services.
- Pay the lowest monthly premium.

- The plan that divides the cost between the monthly premiums and out-of-pocket costs when you get health care services.
- Pay a mid-range monthly premium.

- The plan that has a higher monthly premium, but offers you lower out-of-pocket costs. This plan will work best if you need regular health care services.

- This will be the highest cost for when you get health care services.
- This will be the mid-range cost for when you get health care services.
- Pay a higher monthly premium.
- This will be the lowest cost for when you get health care services.

Note: Multiple American Indian/Native American plans are offered for each metal level.

Providers should use NaviNet® to verify eligibility and benefits information. Bronze, Silver and Gold Metal level benefits can be found at https://www.amerihealthcaritasnext.com/fl.

Covered Services

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

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

The Schedule of Benefits and other policy documents are available on request by contacting our Member Services team at 1-833-999-3567, Monday - Friday from 8 a.m. – 8 p.m. You may also access policy documents online at https://www.amerihealthcaritasnext.com/fl.

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

Abortion Services

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

Accident-related Dental Services

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

Allergy Testing and Treatment

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

Ambulance Services

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

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

- From an acute facility to a subacute facility or setting
- From an out-of-network hospital or facility to an in-network hospital or facility
- To a hospital that provides a higher level of care than was available at the original hospital or facility
- To a more cost-effective acute care facility
- Cost of transporting a newborn to and from the nearest available facility that is appropriately staffed and equipped to treat the newborn's condition, when the transportation is certified by the attending physician as necessary to protect the newborn's health and safety. Coverage for transportation may not exceed the usual and customary charges, up to $1,000.

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

Autism Spectrum Disorders (ASDs)

We will cover ASD services for an individual younger than 18 years of age or an individual 18 years of age or older who is in high school and was diagnosed as having a developmental disability at 8 years of age or younger. Covered health services include the assessment, diagnosis, and treatment of ASDs, including:

- Well-baby and well-child screening for diagnosing the presence of ASD
- 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. Applied behavioral analysis services shall be provided by an individual certified per Florida law.
- Habilitative or rehabilitation services, including, but not limited to, occupational therapy, physical therapy, or speech and language therapy, or any combination of those therapies
- Pharmacy services and medication as covered under the terms of this policy
- Psychiatric care
- Psychological care, including family counseling
- Therapeutic care, which includes applied behavioral analysis

Biofeedback

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

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. Bone mass measurement services require prior authorization.

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.

Child Health Supervision Services

We will cover physician-delivered or physician-supervised child health supervision services from the moment of birth through age 16. Services are covered as follows:

- Periodic examinations which include a history, a physical examination, a developmental assessment, and anticipatory guidance.
- Appropriate immunizations.
- Laboratory tests.

Services and periodic visits shall be provided per prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Chiropractic Care

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

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

- Chiropractic services that are a part of a maintenance program.
- Charges for care not provided in an office setting.
- Infusion therapy or chelation therapy.
- Maintenance or preventive treatment consisting of routine, long-term, or not medically necessary care provided to prevent reoccurrences or to maintain the patient's current status.

- Manipulation under anesthesia.
- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law.
- Vitamin or supplement therapy.

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

Complications of Pregnancy

We cover medically necessary services and supplies for treatment of complications of pregnancy. Complications of pregnancy will be treated the same as any other illness. A non-elective cesarean section is considered a complication of pregnancy.

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:

- Medical and nutritional services, oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate.
- Prosthetic treatment, such as obturator, speech appliances and feeding appliances.
- Orthodontic treatment and management.
- Prosthodontic treatment and management.
- Otolaryngology treatment and management.
- Audiological assessment, treatment, and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices.
- Physical therapy, speech and language therapy assessment and treatment.

We will also cover procedures to treat bones or joints of the jaw and facial region caused by a congenital or developmental deformity, disease, or injury. If a Member with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by this plan.

Dental Services

We will cover dental treatment or surgery determined to be medically necessary by a network Provider when the dental condition is likely to result in a medical condition if left untreated. General anesthesia and hospitalization services are covered when a network Provider determines these services are needed to ensure the safe delivery of necessary dental care for a covered person who:

- Is younger than 8 years of age, and a licensed dentist and the child's physician licensed under Florida state law determine the child needs dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

- Has one or more medical conditions that would create significant or undue medical risk for the individual during the delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

This benefit does not cover services to diagnose or treat dental disease. General anesthesia and hospital services need prior authorization.

Diabetes Services and Supplies

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

- Diabetes care management and monitoring equipment, including certain supplies that may be covered under your pharmacy benefit.
- Diabetes education when a network Provider who specializes in the treatment of diabetes certifies that services are medically necessary.
- Exams, including diabetic eye examinations and foot examinations.
- Insulin pumps and supplies needed for the insulin pumps.
- Nutritional counseling and home health nutritional guidance.
- Outpatient diabetic education and medical nutrition therapy services ordered by a physician and provided by appropriately licensed or registered health care professionals.
- Podiatric appliances for the prevention of complications associated with diabetes.
- Routine foot care.

Diagnostic Services — Outpatient

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

Dialysis Services — Outpatient

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

Durable Medical Equipment (DME) and Devices

We cover medically necessary DME ordered or provided by a physician. DME may require a prior authorization, and we reserve the right to approve rental instead of purchase of the DME. Examples of DME include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), prosthetics, and wheelchairs. We will provide coverage for prescription and nonprescription enteral formulas for home use when prescribed by a network Provider for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Care for inherited diseases of amino acids and organic acids is covered for a covered person up to age 25 and shall include food products modified to be low protein.

Emergency Services

We will cover services needed to start treatment and stabilize your emergency medical condition. These services may include a hospital or facility charge, supplies, and associated professional services. If the Member is admitted to the hospital from the emergency room, any applicable copayment for emergency room services will not apply. If the Member is admitted to an out-of-network hospital from the emergency room, they must notify us within 24 hours. When the Member is stabilized, we will transfer them by ambulance to the closest appropriate in-network hospital or facility. Coverage will only apply if the condition meets the definition of an emergency medical condition, but the Member does not need to notify us in advance before seeking treatment for an emergency. Emergency services and some post-stabilization services received from an out-of-network Provider will be covered at the in-network benefit level. The out-of-network Provider is prohibited from billing the Member more than their in-network cost-share.

Family Planning Services

Family planning services covered under this plan include counseling and education about family planning; injectable contraceptive medication administered by a physician; intrauterine devices, including insertion and removal; and surgical sterilization (vasectomy, tubal ligation). Certain contraceptive medications may be covered under the pharmacy benefit.

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

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

Habilitative Services

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

Covered health services also include therapy for a child who is not walking or talking at the expected age, services provided for people with disabilities in a variety of inpatient and/or outpatient settings, chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function. This applies when a network chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders on an outpatient basis.

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

- Charges for care not provided in an office setting.
- Chelation therapy.

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

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

Healthy rewards program

AmeriHealth Caritas Next makes available to Members an optional healthy rewards program which allows them to earn incentives and rewards for completing different activities at no cost. These incentives and rewards are available to Members as long as they are active on our policy. If the Member's coverage ends under this policy, all incentives and rewards under this program will also end. Benefits offered under this program are in addition to the benefits described in this policy and certain terms and conditions may apply. Members may get additional information on the healthy rewards program by contacting the Member Services phone number on their Member ID card.

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 helping with activities of daily living. Part-time home health care services days are limited to less than eight hours per day and cannot exceed 40 hours per week. For intermittent home health care services, days are limited to two hours per visit, per day. Please refer to your Schedule of Benefits for more information on your home health care benefit and limitations that may apply.

Hospice care

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

Hospital services

This plan covers inpatient hospital services and physician and surgical services for the treatment of an illness or injury and associated services and supplies for this care, including anesthesia, subject to prior authorization. Treatment may require inpatient services when they cannot be adequately provided on an outpatient basis. We will provide coverage for pre-admission testing.

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. Treatment performed outside the hospital will be paid the same as if performed in a hospital, provided it would have been covered on an inpatient basis.

Mastectomy and Breast Cancer Reconstruction

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

- All stages of reconstruction of the non-diseased breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Inpatient discharge decisions following mastectomy procedures will be made by the attending physician in consultation with the patient. Length of post-mastectomy inpatient stays are based on the unique characteristics of each patient, taking into consideration their health and medical history. The Member's length of inpatient stay will not be less than the time frame determined to be medically necessary by their treating physician. We will provide coverage for outpatient postsurgical mastectomy follow-up care, in keeping with prevailing medical standards, by a licensed health care professional qualified to provide postsurgical mastectomy care. The treating physician, after consultation with the covered person, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the insured patient.

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 Member Services at 1-833-999-3567.

Mental Health and Substance Use Services

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

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

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

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

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

AmeriHealth Caritas Next complies with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We provide coverage for mental health and substance use services in parity with medical or surgical benefits within the same classification or subclassification.

Prior authorization is required for abuse-deterrent opioid analgesic drug products.

Osteoporosis Services

We will cover the medically necessary screening, diagnosis, treatment, and management of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Other Practitioners/Provider Office Visits

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

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

We will cover facility charges for covered health services delivered in an outpatient setting for treatment of an illness or injury, including, when applicable, surgical services and associated services and supplies for this care, including anesthesia, subject to prior authorization. Covered services performed in an ambulatory surgery center will be covered if such service would have been covered under the policy as an eligible inpatient service.

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 health services include: one comprehensive low vision exam every five years and low vision aids; one routine eye exam per calendar year and one pair of eyeglasses (with standard frames and lenses) or contact lenses per calendar year. Please refer to the Schedule of Benefits for additional information and any limitations.

Physician services for sickness and injury

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

Pregnancy Services

Covered health services include prenatal care, delivery, postnatal care, and services for any related complications of pregnancy. We will cover services including those that may be provided by a certified nurse midwife, licensed midwife, or a stand-alone birthing center. Coverage also includes well-baby care in the hospital or birthing center. Complications of pregnancy are treated the same as any other illness. An emergency (non-elective) cesarean section is considered a complication of pregnancy.

The Member's coverage for the length of a maternity and newborn hospital stay or follow-up care outside of the hospital will not be limited to a time period less than what is determined to be medically necessary by their treating obstetrical care Provider and pediatric care Provider per prevailing medical standards and consistent with guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. We will provide coverage for post-delivery care for a mother and her newborn. The post-delivery care includes a postpartum assessment and newborn assessment which can be provided at a network hospital, attending physician's office, outpatient maternity center, or in the home by a network qualified licensed health care professional trained in mother and baby care. This coverage also includes physical assessment of the newborn and the mother, and any medically necessary clinical tests and immunizations, in keeping with the prevailing medical standards.

Prescription Drugs

We use a pharmacy benefits management (PBM) organization, PerformRx, to help manage the Member's prescription drug benefit, including specialty medications. The Member will need to fill their prescription medications from a network pharmacy to for it to be covered under their prescription drug benefit. Prescriptions can be filled at either a retail network pharmacy or through our mail-order network pharmacy. As with obtaining any service under our plan, the Member will need to show their Member ID card when they fill or obtain their prescription medications.

The list of prescription drugs covered under this plan is also called a formulary. The formulary covers both brand (preferred and non-preferred) and generic medications and will determine what the Member's out-of-pocket costs will be for medications under our plan. The formulary is occasionally subject to change, but we will provide written notice to the Member before any negative changes take effect and will work with the Member and their prescriber to switch to another covered medication if they are on a long-term prescription. The formulary listing is available on request by contacting Member Services at 1-833-981-7967, Monday – Friday from 8:00 a.m. – 6:00 p.m. excluding holidays. A searchable formulary is available at https://www.amerihealthcaritasnext.com/fl/view-plans/searchable-drug-list.aspx. The Member can enter a medication name to see if it is covered on the formulary, what drug benefit tier it is on, and if there are any limitations such as Prior Authorization, Step Therapy, Quantity Limits or Age Limits. There is also a printable formulary document at https://www.amerihealthcaritasnext.com/fl/members/find-a-provider-or-pharmacy.aspx. It shows all the medications on the formulary, their drug benefit tiers, and any limitations.

We will cover prescription drugs used in the treatment of diabetes, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis. We will cover certain off-label uses of

cancer drugs per Florida law. The Member's health benefit plan does not exclude coverage of any prescription drugs prescribed for the treatment of cancer solely on the basis that the drug is not approved by the Food and Drug Administration (FDA) for a particular indication. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendia (summaries of drug information that are compiled by experts who have reviewed clinical data on drugs): (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium®; (2) The Thomson Micromedex DrugDex®; (3) American Hospital Formulary Service and Lexi-Drugs ; or (4) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services. The Member's health benefit plan also covers the medically necessary services associated with the administration of these drugs. Notwithstanding this section, if the cost-sharing requirements for intravenous or injected cancer treatment medications under the policy or contract are less than $50 per month, then the cost-sharing requirements for orally administered cancer treatment medications may be up to $50 per month.

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

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

To make a request for coverage of a non-formulary drug, the Member, or their authorized representative may call us at 833-981-7967. Or the Member's prescribing Provider may call us at phone number 833-982-7977, fill out the online submission form at https://ppa.performrx.com/PublicUser/OnlineForm/OnlineAbarcaSingleForm.aspx?cucu_id=vrRiF1UyflQOh8M9wgCQpw%3d%3d or fax to 1-844-470-2507. Requests can also be sent by mail to:

PerformRx/AmeriHealth Caritas Next
P.O. Box 516
Essington, PA 19029

If submitting a request by mail or by fax we recommend the Member or provider view the online submission form or contact us by phone to ensure all applicable and necessary information is included in their request.

Once the request is received, our PBM will review the request for medical necessity and appropriateness. For a standard exception review, we will make our decision no later than 72 hours of the date we received the request and any additional required information. An expedited (fast) review can be requested if they, their authorized representative, or prescribing Provider believe that the Member's health could be seriously harmed by waiting up to 72 hours for a decision. The urgent circumstance can be indicated on the request for an expedited review. We will provide the decision on expedited requests no later than 24 hours after we receive the request and any additional required information.

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

Preventive Health Care

We cover any preventive services required by federal and state laws or regulations. The Member's deductible, copayment, or coinsurance amounts will not apply if these services are received from an in-network Provider. Services which are ordered by a network Provider to diagnose or treat a medical condition are not considered a preventive care service. Services received are billed at the appropriate cost-share described in the Member's Schedule of Benefits and Evidence of Coverage.

Examples of 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, colonoscopy, and colorectal cancer screenings.
- Cervical cancer screening — examination and laboratory tests for early detection and screening including annual Pap smear, liquid-based cytology, and human papillomavirus detection; this will follow the American Cancer Society guidelines.
- Colorectal cancer screening — annual examinations and laboratory tests for colorectal cancer are covered for any Member who is age 50 or older or is younger than age 50 but is at high risk for colorectal cancer.
- Mammograms — We cover the following mammogram services per benefit period.
    - Baseline mammogram for any woman who is 35 or older, but younger than 40.
    - Mammogram every two years for any woman who is 40 or older, but younger than 50, or more frequently based on the patient's physician's recommendation.
    - A mammogram every year for any woman who is 50 or older.
    - One or more mammograms a year, based on a physician's recommendation for any woman who is at risk for breast cancer because she has:
        i. A personal or family history of breast cancer;
        ii. A history of biopsy-proven benign breast disease;
        iii. A mother, sister, or daughter who has or has had breast cancer; or
        iv. Not given birth before the age of 30. For coverage other than that mandated in the above, we will cover a mammogram, with or without a physician prescription, performed in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health for breast cancer screening.

Coverage is subject to the deductible and cost-share provisions applicable to outpatient visits, and all terms and conditions applicable to other benefits.

- Nutritional counseling.
- Ovarian cancer screening — for female Members age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered.
- Preventive care and screenings for infants, children, and adolescents according to guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women according to guidelines supported by HRSA.
- Prostate cancer examinations, screenings, and laboratory work for diagnostic purposes per the most recent published guidelines of the American Cancer Society.
- Routine immunizations for children, adolescents, and adults who have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

Primary Care Office Visits

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

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, including cardiac rehabilitation and pulmonary rehabilitation, occupational therapy, physical therapy, speech therapy, and chiropractic 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:

- Charges for care not provided in an office setting.
- Chelation therapy.

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

Skilled nursing facility services

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

- Covered health services do not include custodial, domiciliary care, or long-term care admissions.
- Covered health services must be of a temporary nature and must be supported by a treatment plan.
- The admission is ordered by the covered person's attending physician. We require written confirmation from the physician that skilled care is necessary.
- The skilled nursing facility is a network Provider.

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

Specialist visits

Office visits for specialty care services are covered.

Temporomandibular joint (TMJ) disorder

Covered health 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. Payment for splints for the treatment of TMJ dysfunction is limited to one splint in a six-month period unless a more frequent replacement is determined by us to be medically necessary.

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

Transplant services

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

- Bone marrow transplants (BMTs): Your health benefit plan does not exclude BMT procedures recommended by a referring physician or a treating physician on the basis that they are experimental, investigational, or educational, if the procedures are identified in Section 59B-12.001 of the Florida Administrative Code. Covered BMT procedures include costs associated with the donor-patient to the same extent and limitations as costs associated with the insured, except the reasonable costs of searching for the donor is limited to immediate family Members and the National Marrow Donor Program®.

Urgent care services

Covered health services include medically necessary services by a network Provider, including approved facility costs and supplies. The Member's preventive health care services benefits with $0 cost-sharing may not be used at an urgent care center. The Member should first contact their PCP for an appointment before seeking care from another network Provider, but in-network urgent care centers can be used when an appointment with your PCP is not available or in cases where they are sick and cannot wait for an appointment with their PCP.

Exclusions and Limitations

Covered health services must be administered by a network Provider unless the Member receives prior authorization for out-of-network services. In order for a benefit to be paid, the covered health service 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, or intellectual disabilities. Examples of care which extends beyond medical management include, but are not limited to, the following:
    - Educational services such as remedial education including tutorial services or academic skills training.
    - Neuropsychological testing including educational testing such as I.Q. tests, mental ability, and aptitude tests unless these tests are for an evaluation related to medical treatment.
    - Services to treat learning disabilities, behavioral problems, or intellectual disabilities.

- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form.
- 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 (except when bone marrow transplant procedures are recommended by a referring physician).
- Any items or services related to personal hygiene or convenience whether or not they are specifically recommended by a network Provider or out-of-network Provider, such as air conditions, humidifiers, physical fitness equipment, stair glides, elevators/lifts or barrier free home modifications.
- Any medical and/or recreational use of cannabis or marijuana.
- Any prescription or over-the-counter drugs not on the formulary unless an exception is granted.
- Any prescription vitamins, except vitamins prescribed during pregnancy, and fluoride vitamins, or as indicated as covered in the formulary.
- Any services that are not identified as a covered health service under this policy. The Member will be responsible for payment in full for any services that are not covered health services.
- Care given by a family Member or person living with the Member.
- Diabetes prevention programs offered by out-of-network Providers.
- Expenses, fees, taxes, or surcharges imposed by a Provider or facility that are actually the responsibility of the Provider or facility.
- Expenses for appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (for example, dynamic orthotic cranioplasty or molding helmets); except when the appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and expenses for devices necessary to exercise, train, or participate in sports.
- For certain contraceptive services including, contraceptive devices, implants and injections and all related services, contraceptive prescription drugs, except when provided for purposes other than birth control, as required by law.
- 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 inpatient admissions which are primarily for physical medicine or for diagnostic studies.
- For outpatient habilitative and rehabilitative services for which there is no reasonable expectation to keep, learn, or improve skills and functioning.
- For routine or periodic physical examinations, except as otherwise set forth in this document; the completion of forms or the preparation of specialized reports solely for insurance, licensing,

employment or other non-preventive purposes, such as pre-marital examinations, physicals for employment, school, camp, travel or sports, except as mandated by Florida law.

- For services required as a result of a court order or other tribunal unless determined to be medically necessary by your network physician or coverage is required by federal or Delaware state law.
- For the reversal of sterilization or vasectomies.
- For treatment of sexual dysfunction not related to organic disease or injury.
- Hearing Aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of maintenance and repair, except where required by Florida Law.
- Home health - Services rendered by an adult congregate living facility, adult foster home, adult day care center, or a nursing facility.
- Prescription drugs and services to decrease weight loss including weight reduction programs.
- Services provided by a naturopathic physician.
- The following are not covered for at-home treatment or care under this policy's home health care benefit:
    - Care not prescribed in the approved treatment plan.
    - Chemotherapy and radiation therapy.
    - Chronic condition care.
    - Dietary care.
    - Disposable supplies.
    - Durable medical equipment.
    - Homemaker services such as housekeeping, food and meal preparation, and cooking.
    - Imaging services.
    - Inhalation therapy.
    - Laboratory tests.
    - Prescription drugs except home infusion services.
    - Volunteer care.
- The following are not covered under our policy's hospice benefit:
    - Care not prescribed in the approved treatment plan.
    - Financial, legal, or estate planning.
    - Homemaker services such as housekeeping, food and meal preparation, and cooking.

  - Private duty nursing.
  - Respite care.
- The following skilled nursing facility services are not covered under our policy:
  - Convalescent care.
  - Custodial care.
  - Domiciliary care.
  - Intermediate, rest, or homelike care.
  - Long-term care admissions.
  - Protective and supportive care.
- Treatment received outside the United States, except for a medical emergency while traveling in accordance with the emergency services section of this policy.

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

- Abortions, except in the case of rape, incest, or danger to the mother.
- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form.
- Any examinations, tests, screenings or any other services required by:
  - For employment or government-related diagnostic testing, laboratory procedures, screenings, or examinations;
  - A university, school, or college in order to enter school property or a particular location regardless of reason; or
  - A governmental body for public surveillance purposes.
- Covered health benefits that are provided to Members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Member has a legal obligation to pay.
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the Member files a claim for said benefits or compensation.
- For any loss sustained or expenses incurred while on active duty as a Member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
- For behavioral health and substance use disorder services related to:
  - Court-ordered services required for parole or probation.
  - Marital and relationship counseling.
  - Testing for aptitude or intelligence.

    - Testing for evaluation and diagnosis of learning abilities.
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this policy or for correction of a birth defect in a child.
- For fetal reduction surgery.
- For nontraditional alternative or complementary medicine not consistent with conventional medicine. These include, but are not limited to, acupuncture; hydrotherapy; hypnotism; and alternative treatment modalities including, but not limited to, boot camp, equine therapy, wilderness therapy, and similar programs.
- For services related to surrogate parenting.
- For standby availability of a medical Provider when no treatment is rendered.
- 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.
- Services or supplies performed by a professional Provider enrolled in an education or training program when such services are related to the education or training program.
- Services or supplies rendered by a Provider who is a Member of the Member's immediate family.
- Services or supplies that 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.

Prior authorization guidelines

Prior authorization is required to evaluate the Medical Necessity of proposed services for coverage under applicable benefits programs. When referring Members to a hospital, the PCP only needs to refer to the admitting/performing physician, who is then responsible for obtaining prior authorization for the hospital admission.

Responsibilities

Responsibilities of the admitting/performing physician for hospital admissions:

- Make hospital admission arrangements.
- Acquire the following required information:
    - Member name and date of birth.
    - Member ID number.
    - Admission date.
    - Place of admission.
    - Diagnosis.
    - Planned procedure.
    - Medical information to support the prior authorization review request.

- Notify the Member's PCP of the diagnosis, planned procedure, and hospital arrangements.
- Contact the hospital with the prior authorization code.

Refer to the *Utilization Management* section of this manual for more information on prior authorization requirements. Prior authorization requirements are also available on our website at https://www.amerihealthcaritasnext.com/fl.

Change of Network Status

Updating your Provider Information

When submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. You are contractually required to notify us in writing with at least 30 days advanced notice when changing key Provider demographic information.

Providers are required to review current Provider directory data as it is listed in the directory and submit updates or corrections through the Provider Data Intake Form (PDIF) is posted on NaviNet®. The request for validation will occur every 90 days. You will be sent a reminder prior to the due date to remind you to attest to the accuracy of your Provider data. Providers will be given 30 days to attest to the accuracy of Information or submit any changes. Failure to respond in the specified time frame may result in the removal from our Provider directory until you validate your data. The validation process is ONLY utilized for AmeriHealth Caritas Next, this process does not apply to our Medicaid plan.

Instructions are as follows:

- Log on to NaviNet®.
- Select appropriate Health Plan (AmeriHealth Caritas Next).
- Click the Provider Data Information Form (PDIF) link (in the upper left-hand corner of the Plan Central Page).
- On the Provider Selection screen, click the "Please Select a Provider" menu and select a Provider, and hit "Submit".
- You will be taken to the "Provider Self Service" screen; in the bottom right portion of the page, click the box entitled "Proceed to Provider Updates."
- Click the box entitled "PDIF Update."
- Click the Location Selection.
- Click the box for the Provider(s) for whom you want to attest and/or make changes and click the "Next" box in the bottom right potion of the page.
- Review and make changes to the practitioner summaries, if applicable.
- Provide Required Documentation, if applicable.
- Attest and click the "Next" box in the bottom right potion of the page.

Provider directory data changes will be reflected within the online Provider directory within 14 business days. If the change is not reflected in 14 business days, please contact your Provider Network Management Account Executive.

For additional guidance on the PDIF feature, please call AmeriHealth Caritas Next Provider Services department at 1-833-983-3577.

If your practice is not registered with NaviNet®®, you can complete the Provider Change Form and fax it to your Account Executive, but we highly recommend registering. To register, visit https://NaviNet®.navimedix.com.

The recredentialing process is another way we keep your Provider information current. Return your recredentialing application packet promptly or update your Council for Affordable Quality Healthcare (CAQH), Inc. application at least quarterly.

If you have accepted any payments during the year, the Plan must report that income on the annual 1099 Form. All Providers are reminded that practice demographics should be kept current to receive accurate 1099 Forms. Payments will be processed more efficiently if Provider information is current.

Updates resulting in a change on your W-9 form (e.g., changes to a Provider's name, tax ID number, billing vendor or "pay to" address, or ownership) require the following signatures:

- Group practices: A signature from a legally authorized representative (e.g., Physician or other person who signed the Agreement or one who is legally authorized to bind the group practice) of the practice is required.
- Solo practitioners: A signature from the individual practitioner is required.

An updated copy of your W-9 Form reflecting these changes must also be included to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

Closing a PCP Practice to Additional Patients

A participating PCP must notify his or her Account Executive at least 60 days in advance of any intent to close the practice to additional AmeriHealth Caritas Next patients. There are three status levels for offices:

- Open: Practice is accepting new patients.
- Current: Practice is accepting existing patients currently in the practice. Offices with practices designated as "current" will be listed in the Provider Directory as such.
- Frozen/Closed: Practice is not accepting additions to the panel.

Note: Close-of-practice notification should be in writing within 60 days advance written notice of closure and addressed to your Account Executive.

Changing PCPs

A Member can change his or her PCP by calling Member Services or by accessing the Member portal. When Members request a PCP change, they will need to provide a reason for the change. The change will take effect within twenty-four hours.

Note: Providers cannot make a change to a Member's PCP on the Member's behalf.

Resignation/Termination from the AmeriHealth Caritas Next Network

Providers who choose to resign from the network should first contact their Account Executive to discuss the reason for the resignation. In addition to the telephone call, the Provider must give the network at least 90 days advance written notice in order to terminate network participation.

Written notice can be sent to:

AmeriHealth Caritas Next
Provider Correspondence
P.O. Box 7349
London, KY 40742-7349

In accordance with your contractual obligation to comply with our policies and procedures and professional licensing standards, a specialist or specialty group must notify affected Members if a specialist leaves the group or otherwise becomes unavailable to AmeriHealth Caritas Next Members or if the group terminates its agreement with AmeriHealth Caritas Next.

To help ensure continuity and coordination of care, we notify Members affected by the resignation/termination of a PCP or PCP practice site at least 30 days prior to the effective date of termination and assist them in selecting a different Provider or practice site. AmeriHealth Caritas Next's notification of PCP resignation/termination does not relieve the PCP from his or her professional obligation to also notify his or her patients of the resignation/termination. Call Provider Services at 1-833-983-3577 with any questions.

Patient Transition from a Pediatrician to an Adult PCP

Pediatricians should systematically alert adolescents who are approaching the maximum age for patients treated in their practice to allow them to transition smoothly to a new PCP who has experience in treating adults.

If Members require further assistance on how to switch from a pediatrician to a new PCP, ask them to call Member Services at the telephone number on their ID card.

New Member Continuity of Care

The Plan will provide ongoing Medical or Behavioral Health services and coordination to assist Members who have an ongoing special condition or are engaged in an active course of treatment when a Member is new to the Plan or a provider is terminated from the Plan network.

- New enrollees may continue a course of treatment with non-participating physician/provider for the lesser of a transitional period of up to ninety (90) days or until the treating provider releases the

patient from care from the effective date of enrollment in a managed care plan, provided the requirements for an ongoing course of treatment are met.

- Existing enrollees who recently enrolled in a Delaware Qualified Health Plan may continue a course of treatment with a non-participating physician/provider for the lesser of a transitional period of up to ninety (90) days or until the treating provider releases the patient from care, provided the requirements for an ongoing course of treatment are met.
- Upon member request, Florida members have a right to continue to receive health care services from their non-participating physician/provider for the lesser of up to 90 days or until the treating provider releases the patient from care. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
- In the case of pregnancy, pregnancy from the start of the second trimester.
- In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

Terminated Providers Continuity of Care

The Plan provides continuing coverage of covered services for Members with a terminated Provider when the Provider is terminated from the Plan network in the following circumstances:

- The Provider chooses to end participation in the Plan network.
- The Provider’s contract expires or is not renewed.

After termination of a Provider’s contract for any reason, or in the event of payer insolvency, Provider shall continue provide covered services to Members at the current contracted rate when inpatient care of Members is ongoing, until patient is ready for discharge.

In situations where the Provider termination is related to quality of care or fraud, the Plan care management staff assists the Member to identify and transition to a new Provider. Refusal to offer a transitional period in this scenario is not subject to grievance review.

The Plan will notify Members timely of their right to elect continuation of coverage of treatment upon enrollment into the Plan or upon notification of a Provider terminating from the network.

The Plan shall include a clear description of a Member’s rights under this section in its Evidence of Coverage and summary plan description.

Members will be responsible for copayments and deductibles as per their benefit plan.

Terminated/Out-of-Network Providers Continuity of Care

The Plan conditions this coverage of continued treatment by an out-of-network/terminated Provider on the following terms and conditions:

- The Provider agrees to accept the prevailing rate based on contracts the Plan has with the same or similar Providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the Plan and the insured for all covered services.
- The Provider agrees to provide to the Plan UM program the necessary medical information related to the care provided. The Plan UM program shall not override the professional or ethical responsibility of the Provider or interfere with the Provider's ability to provide information or assistance to the Member.
- The Provider agrees otherwise to adhere to the Plan's established policies and procedures for participating Providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the Plan, and Member hold harmless provisions.
- The Member or the Member's representative notifies the Plan within 45 days of the date of enrollment or notification of terminating Provider that they elect to continue receiving treatment by the Provider.
- The Provider agrees to discontinue providing services at the end of the transition period pursuant to this section and to assist the Member in an orderly transition to a network Provider.
- The services provided are covered in the Member's benefit plan.

The Member will not be prohibited from continuing to receive services from the Provider at the Member's expense.

Members with Ongoing Special Conditions Continuity of Care

The Plan Members who are engaged in an Ongoing Course of Treatment and/or who have an Ongoing Special Condition with a Provider who is terminated from the Plan network will have their services covered with that Provider up to 6 months, as determined by the treating health care Provider, after the date of Provider termination with the below exceptions. If the Provider is terminated due to quality of care or program integrity (fraud), services will not be continued beyond the Provider termination date. If the Provider is terminated and the Member needs assistance selecting another Provider, they are encouraged to call our Rapid Response Team at 1-833-435-7708.

Member Circumstances for Coverage	Timeframe – Duration
Members who were determined to be terminally ill at the time of enrollment/Provider termination and the Provider was treating the terminal illness prior to enrollment/Provider termination.	For new enrollees: Up to 90 days for a new enrollee continuing services with a prior provider who is not contracted with the Plan network. For current members whose provider has terminated: Up to six months for a member continuing services with a terminated provider.

Member Circumstances for Coverage	Timeframe – Duration
Members who are scheduled for a surgery or inpatient stay who were scheduled prior to the Plan effective date/Provider termination date.	For new enrollees: Through the date of discharge after completion of the surgery or inpatient stay *and* Through post-discharge follow up care occurring within 90 days after the discharge that is related to that surgery or inpatient stay. For current members whose provider has terminated: Through the date of discharge after completion of the surgery or inpatient stay *and* Through post-discharge follow up care occurring within 6 months after the discharge that is related to that surgery or inpatient stay.
Members who are on the schedule for or on a waiting list for an organ transplant who were scheduled or placed on the waiting list prior to the Plan effective date/Provider termination date.	For new enrollees: Through the date of discharge after the completion of the transplant *and* Through post-discharge follow-up care related to the transplant occurring within 90 days after the date of discharge. For current members whose provider has terminated: Through the date of discharge after the completion of the transplant *and* Through post-discharge follow-up care related to the transplant occurring within 6 months after the date of discharge.

Member Circumstances for Coverage	Timeframe – Duration
Members who are pregnant in the second or third trimester at the time of their enrollment with the Plan Provider termination.	For new enrollees: Up to 60 days post-partum for those in their 2nd or 3rd trimester. For current members whose provider has terminated: Through the duration of their pregnancy and completion of postpartum care in any trimester of pregnancy.

At the end of the transition period, or sooner at the request of the Member, the Plan and the non-participating Provider will assist the Member to identify and transition to a participating Provider for additional services.

Terminating a Member from a Practice

If a situation arises when a PCP or other treating Provider initiates termination of its Provider-patient relationship and needs to release a Plan Member from his or her practice, there are some important things to remember. The PCP or treating Provider must notify both the Member and the Plan in writing within 30 calendar days if terminating a Member from his or her practice.

To notify the Plan, the Provider must contact his or her Account Executive or Provider Services, or address correspondence to:

AmeriHealth Caritas Next
Provider Correspondence
P.O. Box 7349
London, KY 40742-7349

The Provider must also continue treating the Member for current medical conditions for 30 days after ending the Provider-patient relationship to allow time for the Member to select a different treating Provider. During this time, we will assist the Member in selecting a different PCP or other treating Provider. If the Member asks the Provider or office staff for assistance in selecting a new PCP or other treating Provider, they should be referred to Member Services at 1-833-999-3567.

In the event the Member is threatening or violent towards the Provider or office staff, the Member's access to the office may be terminated immediately and the Member will be notified in writing.

Non-discrimination

Physicians cannot discriminate against any Member based upon race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions);

cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.

Medical Record Requests

When a Provider initiates termination of the Provider-patient relationship with the Member, the Provider cannot charge Members for requests for copies of medical records. The Provider must facilitate the sharing of such records among health care Providers directly involved with the Member's care.

Member Grievances and Appeals

Sometimes AmeriHealth Caritas Next may decide to deny or limit a request a Provider makes for a Member for benefits or services offered by our Plan. To keep the Member satisfied, we provide processes for filing a grievance or appeal. Members, or their authorized representatives, have the right to file a written or oral grievance, file an appeal, and right to an external review with respect to certain adverse benefit determinations or appeals not decided in their favor.

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

Our grievances and appeals processes are in place to address concerns the Member may have with a service issue, quality of care, or the denial of a claim or request for service. Concerns related to the denial of a claim or request for service are considered appeals. Our grievance process is available for review of any policy, decision, or action we make that affects the Member.

If a Member needs help with filing a grievance or appeal, we will help walk them through the process. This includes help with completing forms, providing interpreter and translation services, or providing TTY support and ancillary aid. Additionally, free letter translations are available on request. This service is provided to Members at no charge by contacting Member Services at 1-833-999-3567, Monday – Friday from 8:00 a.m. – 8:00 p.m.

Grievances

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

A grievance can be provided to us at any time by the Member or their authorized representative by calling Member Services at the toll-free phone number 1-833-999-3567 or in writing at:
Member Grievances
AmeriHealth Caritas Next
P.O. Box 7450
London, KY 40742-7450

On filing a grievance, the Member must include any information they believe supports their case. We will carefully consider the issue(s) the Member has raised, and we will never charge the Member anything to file a grievance. Filing a grievance will also never affect the Member's benefits.

Once we have received the Member grievance, we will send them written acknowledgement of receipt within five business days of receiving it. A complaint submitted by a Member about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in this policy.

After we research the Member's concern, we will send the Member and, if applicable, their authorized representative a written notice on how the concern has been resolved. In most instances, we will provide the Member with this written notice within 60 calendar days or within 90 days if the grievance involves the collection of information outside the service area. These time limitations will be suspended if we notify the Member or Provider of the need for additional information to properly review their grievance and that the above-mentioned time frame is on-hold until such information is provided. Once we receive the requested information, the time allowed for completion of the grievance resumes.

If our decision is not in the Member's favor, the written notice will have:

- The qualifications of the person or persons who reviewed the Member's 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.

The Florida Office of Insurance Regulations is available to help insurance consumers with insurance-related problems and questions. The Member may ask by phone at 1-877-693-5236.

At any time, the Member can request free copies of all records and other information we have relevant to their written grievance, including the credentials of any health care professional we consulted. To obtain copies, the Member may contact Member Services at 1-833-999-3567.

Expedited Grievance

If the Member's grievance regards a decision or action on our part that could significantly increase risk to the Member's life, health, or ability to regain maximum function, the Member can file a request for an expedited grievance with our Member Services department by phone 1-833-999-3567 or in writing at:

Member Grievances
AmeriHealth Caritas Next
P.O. Box 7450
London, KY 40742-7450

Expedited reviews will be evaluated by an appropriate clinical peer or peers. We will notify the Member orally of the determination within 72 hours or as expeditiously as possible, after receipt of the expedited review request. We will then send written confirmation to the Member within two business days. Expedited reviews

will meet all requirements of non-expedited reviews as described in our grievance procedures and per Florida law.

Standard Appeals

The Member or their authorized representative can file an appeal of an adverse benefit determination verbally by calling Member Services at 1-833-999-3567 or in writing to:

Member Appeals
AmeriHealth Caritas Next
P.O. Box 7101
London, KY, 40742-7101

An appeal must be filed within 180 days from the date of our written notice denying the Member's claim or their request for service. The appeal procedure is voluntary on the part of the Member and an appeal may be initiated and/or proposed by the Member or authorized representative, including their Provider. Unless the Member is requesting an expedited appeal, a verbal appeal must be followed up with a written and signed appeal. When the Member makes a verbal appeal, we will let them know how to file a signed written appeal. We will also help the Member with filing the written appeal if they need it.

Verbal Appeals

The date the Member makes their verbal appeal counts as the date of receipt of their appeal. However, we will not be able to investigate their appeal until we have received their signed written appeal. We will send the Member written notice acknowledging receipt of their verbal appeal within five calendar days. If we do not receive the Member's signed written appeal within 180 calendar days of the adverse benefit determination, we are not required to process their appeal. We will attempt to contact the Member five calendar days before this 180-day period expires to remind them to send us the written appeal. If we still do not receive the Member's written appeal before this deadline, we will send them a written notice within five calendar days of our inability to process their verbal appeal.

Once we have received the Member's written appeal, we will begin researching their appeal. Within five business days after receiving a request for a standard, non-expedited appeal, we will provide the Member with the name, address, and phone number of the coordinator and information on how to submit written material. The Member or their authorized representative will be allowed to access any medical records or other documents we have that relate to the subject of the appeal at no cost to them. The Member can ask for these records and documents by calling Member Services at 1-833-999-3567, Monday – Friday from 8 a.m. – 8 p.m. If the review required physician review, the physician reviewing the Member's appeal will:

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

The Provider or Member can provide evidence to support the Member's appeal by phone, in writing, or in person. Once we have made a decision on the Member's appeal, we will send them written notice of the decision no later than 30 calendar days for pre-service requests and 60 calendar days for post-service requests after receiving the appeal. If the appeal concerns continuation of a service that the Member is currently

receiving, the Member can continue receiving the services being appealed either until the end of the approved treatment period or until the determination of the appeal.

The Member may be financially responsible for the continued services if the appeal is not approved. The Member can request continued services by calling Member Services at 1-833-999-3567. Note: The Member 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 the Member or their authorized representative either verbally or in writing. The Member can file a request for an expedited appeal with our Member Services department by phone at 1-833-999-3567 or in writing at:

Member Appeals
AmeriHealth Caritas Next
PO Box 7101
London, KY, 40742-7101

An expedited appeal will be made available when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function or, in the opinion of a physician with knowledge of the Member's medical condition, would subject them to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. The Member's Provider can also file a verbal request for an expedited appeal. We will not require written follow-up for a verbal request for an expedited appeal. We may require documentation of the medical justification for an expedited appeal.

We will assign the request for an expedited appeal to a clinical peer. The Member will have the opportunity to provide evidence in support of their appeal by phone, in writing, or in person. When we have made a decision on the appeal, we will try to notify the Member verbally of our decision within 72 hours of receiving the expedited appeal request. If we deny the request for the appeal to be processed in an expedited manner, we will handle the request as a standard appeal and will send written notice to the Member or their authorized representative that we have denied their request for an expedited appeal. The Member have the right to submit a grievance if the expedited appeal request is handled as a standard appeal.

We will, in consultation with a medical doctor, provide expedited review and communicate the decision verbally to covered Members and their Providers as soon as possible, but not later than 72 hours after receiving the information justifying expedited review. We will communicate our decision in writing within 2 business days after verbal notification was provided. 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. Retrospective adverse benefit determinations are not eligible for expedited review.

The Member or their authorized representative may access any medical records or other documents that we have and that are related to the subject of the expedited appeal at no cost to the Member. The physician reviewing the expedited appeal will:

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

Independent External Review Procedure:

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

- Receive an adverse benefit determination decision.
- Receive an appeal decision upholding an adverse benefit determination decision — also known as a final determination.

When processing the request for external review, we will require the Member to provide a written, signed authorization for the release of any of the Member's medical records that may need to be reviewed for the purpose of reaching a decision on the external review. If the Member has any questions or concerns regarding the independent external review process, please contact Member Services at 1-833-999-3567.

The Member also may contact the Florida Office of Insurance Regulation (FLOIR) at:

200 East Gaines Street
Tallahassee, FL 32399
Phone: 1-850-413-3140
Fax: 1-803-737-6231
https://www.myfloridacfo.com/division/consumers/https://floir.com/home]

Exhaustion of Internal Appeals

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

- They completed our appeal process and received a final determination from us; or
- They received notification that we have agreed to waive the exhaustion requirement; or

  We did not issue a written decision within the time frames outlined in the expedited and standard appeals section of this policy after receiving all information necessary to complete the appeal unless the Member or their authorized representative agreed to a delay; or

The Member submits an expedited external review request at the same time as an expedited internal appeal with us.

Eligibility for Independent External Review

For a Member's request to be eligible for external review:

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

If the request for a standard external review is related to a retrospective adverse benefit determination (an adverse benefit determination that occurs after the Member has received the services in question), they will not be eligible to request a standard review until they have completed our internal review process and receive a written final determination notice. An expedited external review is not available for retrospective adverse benefit determinations.

Standard External Review Requests

The Member's request for standard external review must be submitted in writing to AmeriHealth Caritas Next within four months of receiving our notice of final determination that the services in question are not approved. The Member can fax the request to 1-833-435-2967 or mail it to:

Member Appeals
AmeriHealth Caritas Next
PO Box 7101
London, KY, 40742-7101

Expedited External Review Requests

An expedited external review of an adverse benefit determination decision may be available if:

- The treating physician certifies that the Member has a serious medical condition where the time required to complete either an expedited internal appeal or a standard external review would reasonably be expected to seriously jeopardize the Member's life or health or would jeopardize their ability to regain maximum function; or
- The request for external review concerns an admission, availability of care, continued stay, or health care service for which the Member received emergency care as defined by state law, but have not been discharged from the facility.

Expedited external review requests must be submitted within four months from the date on the final determination notice. The Member can submit their request either verbally by contacting Member Services at 1-833-999-3567 or in writing at the following address:

Member Appeals
AmeriHealth Caritas Next
PO Box 7101
London, KY, 40742-7101

The Member may also fax the request to 1-833-435-2967.

IRO External Review Eligibility Determination

Within five business days of receipt of the request for a standard external review, and as expeditiously as reasonably possible for expedited external review requests, we will complete a review of the Member's request to determine if the Member meets the eligibility requirements for external review. If the Member does not meet the criteria for external review eligibility we will notify the Member, the Provider, or the authorized representative who submitted the request of our eligibility determination within one business day of our review decision. If a request is made for an expedited external review, we will make a determination of whether the request meets expedited requirements in consultation with a medical professional. If the request is not accepted for expedited review, we may either:

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

If you or the Member are dissatisfied with our decision, the Member may contact the Florida Office of Insurance Regulation (FLOIR) for further help.

IRO Assignment

If the Member's request for external review is accepted, we will assign an IRO on a rotating basis. We are required to submit all documents and any information considered in making the adverse benefit determination or final determination to the IRO within five business days of receipt of the request for standard external review and as expeditiously as possible (not to exceed 72 hours) for expedited external review requests. If we do not provide all pertinent information to the IRO within the time frame outlined above, it will not delay the conduct of the external review and the IRO may end the external review and make a decision to reverse the adverse benefit determination or final determination. If this occurs, the IRO will immediately contact us and the Member or their authorized representative.

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

IRO Review and Decision

The IRO will communicate its determination within 45 calendar days for standard external review requests and within 72 hours for expedited external review requests from the date they received the initial request. Standard external review request determinations will be provided to the requestor in writing, however,

expedited review request decisions can be communicated verbally or in writing. If the decision is communicated verbally, the IRO will send written notice within 48 hours following verbal notification.

If the IRO's decision is to reverse the adverse benefit determination, we will reverse the adverse benefit determination decision by approving the covered benefit or supply that was the subject of the adverse benefit determination within five business days of receiving notice of the IRO's decision for standard external review requests and as expeditious as reasonably possible for expedited external review requests. If the Member is no longer covered by us at the time we receive notice of the IRO's decision to reverse the adverse benefit determination, we will only provide coverage for those services or supplies they received or would have received before disenrollment if the service had not been denied when first requested.

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

Member Grievances

If a Member has a concern or question regarding the health care services, they have received under the Plan, they should contact Member Services at 1-833-999-3567. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the Member's satisfaction, the Member has the right to file a grievance.

The Plan maintains grievance process, inclusive of appeal rights, whereby a Member may voluntarily request a review of any decision, policy, or action of the Plan that affects that Member. A decision rendered solely on the basis that the Plan does not provide benefits for the health care service in question is not subject to the Plan's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

The Plan will in no way penalize any Member who files a Grievance nor take a retaliatory action against a Provider who acts on behalf of a Member in a Grievance.

Informal Consideration of Grievances

The Plan provides procedures for informal consideration of grievances.

1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the Member, the Plan will treat the request as a request for a first-level grievance review.
2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Member, the Plan will issue a written decision.
3) If the Plan is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the Plan will treat the request as a request for a first-level grievance review.

Any of the following may file a grievance:

- Member.

- If the Member is a minor child, the Member's parent, guardian, or authorized representative.
- In the case of a grievance, an authorized representative, including but not limited to, an attorney, Provider, or other non-legal advocate acting on behalf of the Member.

Grievance Procedures

Members or their representatives can submit grievances orally or in writing at any time. A description of the grievance procedures is attached to the certificate of coverage and Member handbook provided to Members. The description includes a statement informing the Member that the grievance procedures are voluntary and information on the availability of the Florida Insurance Commissioner's office for assistance, including the telephone number and address of the office.

The Plan will:

- Investigate and document the substance of the grievance, taking into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial decision.
- Document the substance of the grievance and any actions taken.
- Ensure that the individuals who make decisions on grievances are individuals who, if deciding any of the following, have the appropriate clinical expertise in treating the Member’s condition or disease:
- Give Members any reasonable assistance in completing forms and taking other procedural steps related to grievances. This includes, but is not limited to, providing interpreter and translation services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Maintenance of Records

The Plan maintains records of each grievance and appeal received and the Plan review of each grievance and appeal, as well as documentation sufficient to demonstrate compliance with the grievance/appeal process. The maintenance of these records, including electronic reproduction and storage.

First-Level Grievance Review

A Member or a Member’s Provider acting on the Member's behalf may submit a grievance.

- A Member may submit written material for consideration in the grievance review. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the Plan will provide the Member with the name, address, and telephone number of the assigned grievance coordinator and information on how to submit written material.
- The Plan will issue a written decision, in clear terms, to the Member and, if applicable, to the Member's Provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance will not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of the individuals reviewing the grievance will be a

medical doctor with appropriate expertise to evaluate the matter. Except for grievances related to the quality of care delivered by the Member's Provider, if the decision is not in favor of the Member, the written decision issued in a first-level grievance review will contain:

- The professional qualifications and licensure of the person or persons reviewing the grievance and appeal.
- A statement of the reviewers' understanding of the grievance or appeal.
- The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Member to respond further to the Plan's position.
- A reference to the evidence or documentation used as the basis for the decision.
- A statement advising the Member of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance or appeal under this section.
- Notice of the availability of assistance from Florida Office of Insurance Regulation (FLOIR), including the telephone number and address of the Program.
- Notice of the availability of assistance from FLOIR, including the telephone number and address of the Program.

For grievances concerning the quality of care delivered by the Member's Provider, the Plan will acknowledge the grievance within 10 business days. The acknowledgement will advise the Member that

- The Plan will refer the grievance to its Quality Assurance Performance Improvement Committee (QAPIC) for review and consideration or any appropriate action against the Provider and
- that Florida law does not allow for a second-level grievance review for grievances concerning quality of care.

Second-Level Grievance Review

The Plan will maintain a second-level grievance review process for Members who are dissatisfied with the first-level grievance. A Member or the Member's Provider acting on the Member's behalf may submit a second-level grievance.

1) The Plan will, within 10 business days after receiving a request for a second-level grievance review, make known to the Member:
    a. The name, address, and telephone number of the grievance coordinator assigned to coordinate the grievance review for the Plan.
    b. A statement of a Member's rights, which include the right to request and receive from the Plan all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any Member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a Provider, family Member, employer representative, or attorney. If the Member chooses to be represented by an attorney, the Plan may also be represented by an attorney.

c. Notice of the availability of assistance from FLOIR, including the telephone number and address of the Program.

2) The Plan will convene a second-level grievance review panel for each request. The panel will comprise persons who were not previously involved in any matter giving rise to the second-level grievance and do not have a financial interest in the outcome of the review. The panel will comprise a minimum of three persons, one of whom may be a plan employee with the appropriate expertise. A person who was previously involved in the matter may appear before the panel to present information or answer questions.

Second-Level Grievance Review Procedures

The Plan's procedures for conducting a second-level grievance review include:

1) The review panel will schedule and hold a review meeting within 45 days after receiving a request for a second-level review.
2) The Member will be notified in writing at least 15 days before the review meeting date.
3) The Member's right to a full review will not be conditioned on the Member's appearance at the review meeting.

Second-Level Grievance Review Decisions

The Plan will issue a written decision to the Member and, if applicable, to the Member's Provider, within seven business (7) days after completing the review meeting. The decision will include:

1) The title and position within the organization of the Members of the review panel.
2) A statement of the review panel's understanding of the nature of the grievance and the pertinent facts.
3) The review panel's decision the Plan and the rationale behind that decision.
4) A description of or reference to the evidence or documentation considered by the review panel in making the decision.
5) A statement that the decision is the Plan's final determination in the matter.
6) Notice of the availability of the Florida Insurance Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

Consumer Assistance Notice

As per statute 641.511, Providers are required to post a consumer assistance notice prominently displayed in the reception area of the Provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
Phone toll-free at (888) 419-3456 / (800) 955-8771 Florida Relay Service (TDD number)

Florida Department of Financial Services
200 East Gaines Street
Tallahassee FL 32399
Phone: (850) 487-9687
Fax: (850) 410-9663

Appeal Procedures

An appeal of an adverse decision must be filed within 180 days from the date of our written notice denying a Member's claim or their request for service. The appeal procedure is voluntary, and an appeal may be initiated and/or proposed by the Member or a person acting on their behalf — such as a relative or other representative, including their health care Provider. The Member may appeal in writing or verbally. The Plan will accept verbal appeals (without written follow up) from Members, personal representative, and performing/prescribing Providers. However, we require authorized consent to send correspondence to Providers and personal representatives. Without that written consent, correspondence will only be sent to the Member although the Plan will accept, and handle appeals submitted by Providers on behalf Members.

The date the Member makes their verbal appeal request counts as the date of receipt of the appeal. We will send the Member written notice acknowledging receipt of their verbal appeal request within three business days. If we don't receive the appeal request from the Member, their Provider, or personal representative with appropriate consent, within 180 calendar days of the adverse benefit determination, we are not required to process the appeal. We will attempt to contact the Member five calendar days before this 180-day period expires to remind them to send us the appeal when a personal representative is involved, and we have not received consent. If we still do not receive the appeal consent in that scenario, before this deadline, we will send the Member a written notice within five calendar days of our inability to process their verbal appeal requested by their Provider or personal representative.

To file an appeal, the Member can call us at 1-833-999-3567 711 or send the request in writing to:

Member Appeals
AmeriHealth Caritas Next
P.O. Box 7101
London, KY, 40742-7101
Fax: 1-833-435-2967

Standard Appeals

Preservice and Post service Standard Appeal Review

Once we have received the Member appeal request, we will begin researching the Member appeal. Within three business days after receiving a request for a standard, non-expedited appeal, we will provide the Member with contact information and information on how to submit written material. The Member or the

Member's 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 the Member. The Provider reviewing the Member's appeal will not have been involved in the previous decision on the Member's claim or request for service and will have the appropriate training in the Member's condition or disease.

The Member will have the opportunity to provide evidence in support of the Member's appeal by phone, in writing, or in person. Once we have made a decision on the Member's appeal, we will send the Member written notice of the decision no later than 30 calendar days after receiving the Member appeal. For Post service Appeals a written notification of the determination will be provided within 60 calendar days of receipt of the request. An appeal may be extended by the Plan, to gather additional information for up to 14 calendar days if the Member agrees to the extension If the Member's appeal concerns continuation of a service that the Member is currently receiving, the Member 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.

The Appeal Reviewer or Medical Director making the determination will not have been involved in any previous level of review or decision-making in the case at issue and not a subordinate of any person involved in the initial determination. The Appeal Reviewer or Medical Director making the determination will also take into account comments, documents, records, and other information submitted by the Member or his/her Authorized Representative without regard to whether such information was previously submitted or considered

The Plan will issue a written decision, in clear terms to the Member and if applicable, to the Member's representative. The written notification will include:

- A statement of the reviewers' understanding of the appeal.
- The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Member to respond further to the Plan's position.
- List of titles and qualifications, including specialties of individuals participating in the appeal review.
- A statement advising the Member of his or her right to an External Review and a description of the procedure for submitting.
- Notice of the availability of assistance from Health Insurance FLOIR, including the telephone number and address of the Program.
- Provide notices that are based on the Members cultural and linguistic needs.

The Member may be financially responsible for the continued services if the appeal is not approved. The Member can request continued services by calling Member Services at 1-833-999-3567.

Note: The Member 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 the Member or the Member's 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. The Member or 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 the Member written notice acknowledging the receipt of the request for an expedited appeal within 24 hours of receiving the request.

We will, in consultation with a medical doctor licensed to practice medicine in Florida, provide expedited review and communicate the decision in writing to the Member and the Member's provider as soon as possible, but not later than four days after receiving the information justifying expedited review. If the expedited review is a concurrent review determination, we will remain liable for the coverage of health care services until the Member have been notified of the determination. We are not required to provide an expedited review for retrospective noncertification.

The Plan will grant an expedited review for all request concerning admissions, continued stay or other health care services for a Member who received emergency services but has not been discharged from a facility.

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

The Plan will issue a written decision, in clear terms to the Member and if applicable, to the Member's representative within 72 hours after receiving the appeal unless verbal notification to the Member or authorized representative is provided. Following verbal notification to the Member or authorized representative, the Plan will provide a written notification within 3 calendar days following the verbal notification. The written notification will include:

- A statement of the reviewers' understanding of the appeal.
- The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Member to respond further to the Plan's position.
- List of titles and qualifications, including specialties of individuals participating in the appeal review.
- A statement advising the Member of his or her right to an External Review and a description of the procedure for submitting.
- Notice of the availability of assistance from Health Insurance FLOIR, including the telephone number and address of the Program.
- Provide notices that are based on the Member's cultural and linguistic needs.
- If the Plan denies the request for an expedited resolution of an Appeal, it will:
    - Transfer the Appeal to the timeframe for standard resolution and follow the standard appeal process.
    - Give the Member prompt oral notice of the denial.

- Send a written notice within two (2) calendar days.
- Allow the Member to file a grievance regarding the denial of the request for an expedited resolution.

Continuation of Services During an Appeal

The Plan will continue ongoing services that are the subject of an Appeal if:

- The appeal is filed timely; within ten (10) calendar days of mailing of the Notice of Adverse Benefit Determination, or the intended effective date of the proposed action.
- The appeal involves termination, suspension, or reduction of previously authorized course of treatment. This does not apply to extensions.
- The service was ordered by an authorized representative.
- The authorization period has not expired.
- The request for appeal was filed before the end of the approved treatment period.
- If the Plan continues or reinstates the Member's benefits while the appeal is pending, benefits are continued until one of the following is met:
    - The Member withdraws the appeal, in writing.
    - The Member does not request an External Appeal within ten (10) calendar days from the date the adverse Appeal decision is mailed to the Member; or
    - The authorization expires or authorization service limits are met.

Independent External Review

The External Review Provision is in the Member Evidence of Coverage and Member Handbook. For a complete description of the external review policies and procedures, including information about when an expedited external review is available, the Member may request a copy from our Member Services department at 1-833-999-3567.

The Florida Office of Insurance Regulation (FLOIR) is also available to help the Member understand external review policies and procedures and the Member's right to request an external review under Florida law. To request an external review or if the Member have additional questions about the Member's right to an external review, contact the FLOIR at:

Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399
1-850-413-3140

Inquiries or applications must be completed online or mailed to the Department along with the fee and required documentation.

If the Member believes the Member are eligible for and request an expedited appeal from the Plan, the Member may be eligible to request an expedited external review from FLOIR. Expedited external review is available if the Member has a medical condition where the time frame for completion of an expedited appeal with us would reasonably be expected to seriously jeopardize the Member's life or health or jeopardize the Member's ability to regain maximum function. However, the Member must have also filed a request for an expedited appeal (even if the Member have not yet received a decision on the appeal) before FLOIR can accept the Member's request for expedited external review.

Provider Complaints/Disputes

Providers may file a dispute/complaint about the Plan's policies or procedures, or any aspects of the Plan's administrative functions, including proposed actions, claims and billing-related issues, and service authorizations.

A complaint is a request from a health care Provider to change a decision made by the Plan related to claim payment; policy, procedure, or administrative functions; or denial for services already provided. A Provider complaint is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

Examples include, but are not limited to:

- Credentialing concerns, such as timeliness, allegation of a discriminatory practice, or policy.
- Claim-related issues, including inaccurate payment, claim denials, and post-service authorization denials.
- Service issues with the Plan, including failure by the plan to return a Provider's calls, frequency of site visits, and lack of Provider network orientation and education.

Providers are encouraged to resolve complaints by contacting their Account Executive or by calling Provider Services at 1-833-983-3577.

To notify the Plan of a grievance, Providers may also mail or fax their complaint with a listing of claims (if applicable) and supporting documentation to:

AmeriHealth Caritas Next
Provider Complaints/Grievances
P.O. Box 7351
London, KY, 40742-7351
1-833-983-3577

Claims Investigation

Providers may initiate a claims investigation about claims no later than 180 days from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claim submission, whichever is later. Inquiries are questions from Providers regarding how a claim was processed. Inquiries can be submitted via phone, online, or written correspondence. An inquiry may or may not result in a change in the payment.

You may open a claims investigation:

- Via NaviNet® with the claim's status inquiry function.
- If you are uncertain about how to conduct and a claims investigation, there is a step-by-step user guide located on the AmeriHealth Caritas Next plan central page.
- By calling Provider Services 1-833-983-3577 and selecting the prompts for the correct department, and then selecting the prompt for claim issues.
- By mailing your request to:

  AmeriHealth Caritas Next
  Attn: Provider Claims Processing
  P.O. Box 7344
  London, KY, 40742-7344

Claim Disputes

Providers who receive an unsatisfactory response to a claim investigation may submit a claim dispute within 60 days of the date of the denial. Claim disputes will be resolved within 30 calendar days. Claim Disputes must be submitted in writing, with supporting documentation, to:

AmeriHealth Caritas Next
Attn: Provider Claim Processing
P.O. Box 7344
London, KY, 40742-7344

If a claim or a portion of a claim is denied for any reason or underpaid, the Provider may file a complaint about the claim within 365 days from the date of service. A telephone inquiry regarding payment or denial of a claim does not constitute a complaint of the claim. Provider Complaints must be submitted in writing, along with supporting documentation, to:

AmeriHealth Caritas Next
Attn: Provider Claim Processing
P.O. Box 7344
London, KY, 40742-7344

Please note: Please include the Member's name and ID, date of service and claim ID.

Refunds for Improper Payment or Overpayment of Claims

If a Plan Provider identifies improper payment or overpayment of claims from the Plan the improperly paid or overpaid funds must be returned to the Plan within 60 days. Providers are required to return the identified funds to the Plan by submitting a refund check directly to the Provider claims processing team:

AmeriHealth Caritas Next
Attn: Provider Claim Processing
P.O. Box 7344

London, KY, 40742-7344

Please note: Please include the Member's name and ID, date of service and claim ID.

Notwithstanding the **30-month period** provided in subsection (6) when a Provider is convicted of fraud, all claims for overpayment submitted to a Provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 **must be submitted to the Provider within 12 months after the health insurer's payment of the claim.** A claim for overpayment may **not be permitted beyond 12 months after the health insurer's payment of a claim**, except that claims for overpayment may be sought beyond that time from Providers convicted of fraud pursuant to s. 817.234. Notwithstanding any other provision of this section, all claims for underpayment from a Provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment may not be permitted beyond 12 months after the health insurer's payment of a claim.

Fraud, Waste, and Abuse

As a Provider participating in the Plan network, you are responsible to know and abide by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of the Plan.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Plan or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the ACA Exchange Program.

Federal False Claims Act

The Federal False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors for payment or approval. Additionally, the FCA prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. When the Plan submits claims data to the government for payment, we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to ensure compliance.

The FCA, through amendments made under the Fraud Enforcement and Recovery Act of 2009, also prohibits knowingly concealing or knowingly and improperly avoiding the return of identified overpayments.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a civil lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

Penalties for violating the FCA include civil monetary penalties (CMPs) ranging from $11,181 to $22,363 (as adjusted by the DOJ under the Federal Civil Penalties Inflation Adjustment Act of 1990) per false claim, and/or exclusion from federally funded programs. In addition, violators are subject to three times the amount of damages sustained by the Federal government because of the illegal act(s) unless the violator has voluntarily disclosed the FCA violation under certain conditions.

Program Integrity

AmeriHealth Caritas Next (the Plan) is a product of AmeriHealth Caritas Florida, Inc.. AmeriHealth Caritas Family of Companies has a dedicated Program Integrity Department charged with preventing, detecting, investigating, and reporting fraud, waste, and abuse (FWA) for all of its health insurance Plans, including AmeriHealth Caritas Next.

The programs of the Program Integrity Department are aimed at the accuracy of claims payments and the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of the Plan, regarding payments or recovery of potential overpayments. The Program Integrity Department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your Provider contract. Examples of these Program Integrity initiatives include:

Prospective (Pre-claims payment)

- Claims editing – A review and adjustment of payments based on an identified deviation from the established industry guidelines standards such as Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state regulatory agencies or plan medical/claim payment policy.
    - Medical Record/Itemized Bill review – A medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
    - Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.
- A review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

Retrospective (Post-claims payment)

- Data Mining – Using paid claims data, the Plan identifies trends and patterns to identify invalid claim payments or claim overpayments that warrant recovery.

- Medical Records Review – Medical records may be requested to validate the accuracy of coding for procedures, diagnosis, or diagnosis-related group (DRG) billed by the Provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
    - Please note if medical records are not received within the requested timeframe, the Plan will recover funds from the Provider. Your failure to cooperate by providing medical records creates a presumption that the claim as submitted is not supported by the records.
- Credit balance review service conducted in-house at the Provider's facility to assist with the identification and resolution of credit balances at the request of the Provider.
- Overpayment Collections – Credit balances that have not been resolved in a timely manner may be referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Compliance with federal and state laws and regulations and other guidance is a priority of the Plan. If you, or any entity with which you contract to provide health care services on behalf of the Plan Members, become concerned about or identifies potential compliance, privacy, fraud, waste, or abuse issues, please contact the Plan by:

Anonymous Hotline and Online Reporting

Phone hotlines are available 24 hours a day, seven days a week at:

- Fraud Waste and Abuse Hotline at 1-866-833-9718
- For compliance, privacy, or ethics concerns: 1-800-575-0417

Emailing to:

- Fraud: fraudtip@amerihealthcaritas.com
- AC Next Compliance: ACNXCompliance@amerihealthcaritas.com
- Corporate Compliance: corpcomp@amerihealthcaritas.com
- Corporate Privacy: privacy@amerihealthcaritas.com

By mail:

Mail a written statement to:

Special Investigations Unit
AmeriHealth Caritas Next
P.O. Box 7318
London, KY 40742

Below are examples of information that will assist the Plan with an investigation:

- Information (e.g., name of individual making the allegation, address, number).

- Name and Identification Number of the suspected individual.
- Approximate dollars involved (if known).
- Place of service.
- Description of the suspected fraudulent or abusive activities.
- Timeframe/date of the suspected activity(ies).

The Program Integrity Department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with applicable federal and state regulations and contractual requirements. Cross-functional teams include the Special Investigations Unit (SIU) and the Claims Cost Containment Unit.

What to Expect as a Result of Special Investigations Unit (SIU) Activities

The SIU reviews all reports of suspected FWA; as a result, you may be asked to provide certain information for the SIU to conduct a thorough investigation. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with FWA. As a result of these claims accuracy efforts, you may receive letters from the Plan or on behalf of the Plan regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns.

- You may be contacted by the SIU Intake Unit to verify a report you filed.
- You may be contacted by investigators regarding an issue they are investigating.
- As a Provider, you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that the terms of your Provider Agreement require you to provide the records for review.

After the SIU completes its investigation, a number of things may occur. We may make a determination that the complaint was unfounded, or we may make a referral to: (1) the FLOIR using FLOIR's defined Fraud, Waste, and Abuse Submission Form, (2) the Florida Department of Justice, or (3) the federal Office of Inspector General, U.S. Department of Health and Human Services, for further investigation. You may receive an overpayment letter that outlines our findings if we determine that monies are owed to the Plan as a result of an overpayment. You could also receive an informational letter that outlines proper procedures that are to be followed for future reference. We may also place you on prepayment review.

Prepayment Review

The Special Investigations Unit (SIU) utilizes the prepayment pending of claims as a corrective action tool. The process automatically pends the Provider's claims so that we may conduct a medical record review prior to payment; the review is conducted to determine whether the documentation supports the claim's billed services. Upon completion of the prepayment review, the Plan will process the claim according to the outcome of the clinical record review. The SIU will monitor billing accuracy while the Provider is on prepayment review. When a Provider's billing accuracy falls into compliance for at least one quarter, the SIU

will consider removing the Provider from prepayment review. Noncompliance with the prepayment review process may result in further actions, up to and including termination from the Plan network.

Claims Cost Containment

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted for potential recovery. Some examples include:

- Incorrect billing from Providers causing overpayment.
- Overpayment due to updates to Provider fee schedules in the claims processing system.
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/ procedure codes, third-party liability, recissions in coverage or retrospective determinations of Member ineligibility.

Refunds for Claims Overpayments or Errors

The Plan and FLOIR encourage Providers to conduct regular self-audits to ensure accurate payment. Improper payment or overpayment of claims from the Plan must be returned to the Plan. If the Provider's practice determines that it has received overpayments or improper payments, the Provider is required to make arrangements within 60 days to return the funds to the Plan. The Plan's Claims Cost Containment Unit is responsible for the manual review of Provider-initiated repayment of overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

AmeriHealth Caritas Next
Provider Refund
P.O. Box 7344
London, KY, 40742-7344

Production of records and examination under oath

When requested by the Plan or designated representatives of federal, State, or local law enforcement and/or regulatory agencies, Providers must produce copies of all medical/financial records requested within the requested timeframe and must permit access to the original medical/financial records for comparison purposes if requested. Some requests may call for an examination under oath.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records as requested, in addition to other remedies, the Plan reserves the right to place the Provider on prepayment review.

Claims

Overview

The Claims section is designed to keep you and your office staff up to date on how to efficiently submit claims to us. Information is included about:

- submitting clean claims as well as electronic transaction channels, including clearinghouse options for electronic claims submission.
- NaviNet®® web portal, our secure Provider portal that expedites processing and payment.

Submit Your Claims to the Correct Plan

IMPORTANT REMINDER: AmeriHealth Caritas Next and AmeriHealth Caritas Florida (our Medicaid plan) are products offered by AmeriHealth Caritas Florida, Inc.

Please be careful to submit your claims to the correct plan. Improper claims submission will result in payment delays.

Submitting Electronic Claims to AmeriHealth Caritas Next:

To submit AmeriHealth Caritas Next claims through electronic data interchange (EDI), please use EDI payer ID number **45408.**

If you have questions, please call your Account Executive or AmeriHealth Caritas Next Provider services at **1-833-983-3577**

Newborn, Adopted, and Foster Child Claims

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. Separate claims should be submitted for the mother and their newborn. Providers should submit the newborn claims under the mother's ID with the newborn's date of birth. Provided the date of service falls within the paid through date or 30-day grace period, the plan will process claims for the first 30 days of the newborn's life under a temporary newborn ID. If the subscriber enrolls the newborn during the 30-day temporary ID window, the newborn will be added using the standard enrollment process and the temporary newborn ID will be removed. AmeriHealth Caritas Next will deny claims submitted under the temporary newborn ID submitted after 30 days of life.

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.

NaviNet® Web Portal

NaviNet®, a Health Insurance Portability and Accountability Act (HIPAA)-compliant, web-based connectivity solution offered by NaviNet®, Inc., an independent company, is a fast and efficient way to interact with us to streamline various administrative tasks associated with our Members' health care.

By providing a gateway to the systems used by the Plan, NaviNet® enables you to submit and receive information electronically with increased speed, efficiency, and accuracy.

For more information on NaviNet®, see the *Administrative Procedures* section of this manual.

Claims Submission Requirements

All claims for services rendered by in-network Providers must be submitted to the Plan within 180 days from the date of service (or the date of discharge for inpatient admissions). Claims submitted by practitioners must be billed on the CMS-1500 or UB-04 or via the electronic equivalent (EDI) of these standard forms. The following information is required on all claims:

- Member's (patient's) name.
- Member's Plan ID number.
- Member's date of birth and address.
- Information advising if the Member's condition is related to employment, auto accident or liability suit.
- Date(s) of service, admission, and discharge.
- Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits.
- Name of referring physician, if appropriate.
- HCPCS procedures, services or supplies codes.
- CPT procedure codes with appropriate modifiers.
- CMS place of service code.
- Charges (per line and total).
- Days and units.
- Physician/supplier Federal Tax Identification Number or Social Security Number.
- National Practitioner Identifier (NPI) and Taxonomy.
- Physician/supplier billing name, address, zip code, and telephone number.
- Name and address of the facility where services were rendered.
- NDCs required for physician-administered injectables that are eligible for rebate.
- Invoice date.
- Provider signature.

Note: The Plan also encourages Providers to submit claims using:

- Plan-assigned tax identification numbers (TIN).
- Plan-assigned Member ID numbers.

Out of Network Providers

The Plan uses network Providers to provide covered services to Members. This means that we will not pay for services Members might receive from out-of-network Providers unless the Member has 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.

Out-of-network Providers are required to submit claims within 180 days from the date of service. Providers or the Member 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 written notice of such a claim is provided to the plan within 180 days of the date of service.

To give notice of a claim, please call the plan at the phone number listed on the Member's ID card to obtain a claim form. The Member must sign the claim form before the Plan will issue payment to the Provider or reimburse the Member for covered services received under this policy. The Member 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
Member Claims Submission
P.O. Box 7345
London, KY, 40742-7345

Reimbursement

Reimbursement will be made only for covered services received in accordance with the provisions of this *Provider Manual*. In the event the Member is required to make payment other than a required copayment, deductible, or coinsurance amount at the time covered services are rendered, the Plan will ask that the Provider reimburse the Member, or the Plan will reimburse the Member by check within thirty (30) days.

Claim Submission Procedures

The Plan is required by federal regulations to capture specific data regarding services rendered to its Members. Providers must adhere to all billing requirements so that the Plan can timely process claims.

When required data elements are missing or invalid, the Plan will reject the claim for correction and re-submission. Claims for billable services provided to Plan Members must be submitted by the Provider who performed the services.

Important: A clean claim is a claim for payment for a covered service provided to an eligible Member on the date of service, which claim is accepted by the Plan's Electronic Data Interchange (EDI) system as complete and accurately submitted, and has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment.

Claims filed with the Plan are subject to the following procedures:

- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of Member eligibility for services under the Plan during the time period in which services were provided.

- Verification that the services were provided by a participating Provider or that an out-of-network Provider has received authorization to provide services to the eligible Member.
- Verification that an authorization has been given for services that require prior authorization by the Plan.

Electronic Claims Submission (EDI)

The Plan encourages all Providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare. Providers who wish to submit electronic claims through ConnectCenter, Change Healthcare's claims management system, may call Change Healthcare at 1-800-527-8133, option 2 for assistance on how to enroll in ConnectCenter.

Electronic claims that are submitted though Change HealthCare's Connect Center use a **4-digit** ConnectCenter Payor identifier (CPID). The CPIDs for AmeriHealth Caritas Next are:

- For AmeriHealth Caritas Next Institutional claims: **7044**
- For AmeriHealth Caritas Next Professional claims: **9427**

There are many different products that may be used to bill electronically. If as you have the capability to send EDI claims to Change Healthcare, whether through direct submission via ConnectCenter or through another clearinghouse/vendor, you may submit claims electronically.

Providers interested in sending claims electronically may also contact the EDI Technical Support at 1-833-983-3577 or email AHCNext@amerihealthcaritas.com to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Change Healthcare's ConnectCenter at 1-800-527-8133, option 2 to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas Next.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.
- AmeriHealth Caritas Next's EDI Payer ID# is **45408**.

Paper Claim Mailing Instructions

Please submit paper claims to the address below:

AmeriHealth Caritas Next
Attn: Claims Processing Department
P.O. Box 7344
London, KY, 40742-7344

Claim Filing Deadlines

All original paper and electronic claims must be submitted to the Plan within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to both capitated and fee-for-service claims. Please allow for normal processing time before re-submitting a claim either through the

EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid Provider or Member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

Unless otherwise agreed to by the Plan and the Provider, failure to submit a claim within the 180-day timely filing deadline does not invalidate or reduce any claim if it was not reasonably possible for the Provider to file the claim within the 180-day period, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Provider, later than one (1) year from the time submittal of the claim is otherwise required.

Rejected Claims

Rejected claims are those returned to a Provider or EDI source without being processed or adjudicated, due to a billing issue. Rejected claims are missing or have invalid data elements, such as the Provider tax identification number or Member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

- Rejected paper claims have a letter attached with a document control number (DCN).
- A DCN is not an AmeriHealth Caritas Next claim number. Rebilling of a rejected claim should be done as an original claim.
- Since rejected claims are considered original claims, the timely filing limits must be met.

Denied Claims

Denied claims are those that were processed in the claims system. They may have a partial payment attached or may have been denied in their entirety. A corrected claim (see below) may be submitted to have the claim reprocessed.

Corrected Claims

A corrected claim is defined as a claim submitted by a Provider that corrects information on the original claim. A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted as indicated below as well as the correct frequency code.

- You can find the original claim number from the 835 Electronic Remittance Advice (ERA), the paper Remittance Advice or from the claim status search in NaviNet®®.
- If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet®® to get the claim number.

Corrected/replacement and voided claims may be sent electronically or on paper.

- If sent electronically, the *claim frequency code* (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values ‘7’ for the

Replacement (correction) of a prior claim and '8' for the void of a prior claim. The Value '6' should not be used.

- In addition, the submitter must also provide the original claim number in *Payer Claim Control Number* (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

Claims Status Inquiry

Providers can check the status of a claim by going to the claims status inquiry function on NaviNet®.

If a Provider does not receive payment for a claim within 30 calendar days from the date of submission, the claims status information can be obtained by:

- Visiting NaviNet®. Log on to https://www.NaviNet®.net for web-based solutions for electronic transactions and information.
- Opening a claims investigation via NaviNet® with the claim's investigation inquiry function.
- Calling Provider Services at 1-833-983-3577 and following the prompts.
- Calling your Account Executive for assistance.

Requests for Claims Investigation

Providers may file an inquiry about claims no later than 180 days from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claim submission, whichever is latest. Inquiries are questions from Providers regarding how a claim was processed. Inquiries can be submitted via phone, online or written correspondence. An inquiry may or may not result in a change in the payment.

You may open a claims investigation:

- Via NaviNet® with the claims status inquiry function.
- If you are uncertain about how to conduct and a claims investigation, there is a step-by-step user guide located on the AmeriHealth Caritas Next plan central page.
- By calling Provider Services 1-833-983-3577 and selecting the prompts for the correct department, and then selecting the prompt for claim issues.
- By mailing your request to:

  AmeriHealth Caritas Next
  Attn: Provider Claims Submission
  P.O. Box 7344
  London, KY, 40742-7344

Claim Disputes

Providers who receive an unsatisfactory response to a claim investigation may submit a claim dispute within 60 days of the date of the denial. Claim disputes will be resolved within 30 calendar days. Claim disputes must be submitted in writing, with supporting documentation, to:

AmeriHealth Caritas Next
Attn: Claim Submission
P.O. Box 7344
London, KY, 40742-7344

Claims Payment Options

Change Healthcare is now partnering with ECHO Health, Inc. (ECHO), a leading innovator in electronic payment solutions, to offer more electronic payment options and to allow healthcare Providers to process electronic payments more efficiently.

AmeriHealth Caritas Next EDI payer ID: **45408**

Through ECHO, the Plan offers four payment options:

- Electronic Funds Transfer (EFT).
- Virtual Credit Card (VCC).
- MedPay.
- Paper check.

Electronic Funds Transfers (EFT)

EFT is the preferred payment option of the Plan. Electronic funds transfers allow you to receive your payments by depositing them directly to the bank account you designate rather than receiving them by paper check or VCC. If you are new to EFT, you must enroll with ECHO for EFT from the Plan.

New to EFT Payments: If you are interested in receiving payment via EFT, setting up EFT is fast and straightforward. In addition to your banking account information, you will need to provide an ECHO payment draft number and payment amount as part of the enrollment authentication.

To sign-up to receive EFT from AmeriHealth Caritas Next and any affiliated plans, visit https://enrollments.echohealthinc.com/efteradirect/enroll. You only need to enroll once for AmeriHealth Caritas Next and any affiliated plans and there is no fee.

To sign up for EFT, from **all** payers you work with to process payments on the ECHO platform, visit https://enrollments.echohealthinc.com/. **A fee for this service may be required.**

Existing EFT Users: If you only have one bank account registered with Change Healthcare, and you are currently receiving EFT payments, your payments will continue to be transmitted electronically by EFT.

If you have more than one bank account registered with Change Healthcare or you have multiple NPIs that will have different bank accounts, please contact ECHO at **1-888-492-5579** at your earliest convenience to ensure that your EFT account is set up correctly and your EFT payments continue successfully.

To ensure continuous receipt of Electronic Remittance Advices (ERAs), you will need to update your practice management system and/or notify your vendor to make the necessary updates to accept the **ECHO Payer ID 58379** in addition to the AmeriHealth Caritas Next **payer ID 45408.**

Virtual Credit Card (VCC)

If you are not currently registered to receive payments electronically, you will receive VCC payments as your **default payment** method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, your Explanation of Payment/Remittance Advice (EOP/RA), and an instruction page for processing. **Normal transaction fees apply based on your merchant acquirer relationship.** To opt out of this VCC payment method, you can contact ECHO directly at **1-888-492-5579**.

Please note: You must have an ECHO draft number to opt out. If you have received previous payments from ECHO, you may use the draft number from another payer. Otherwise, you will need to receive one VCC from AmeriHealth Caritas Next to opt out.

Med-Pay

Offered in partnership with Deluxe Corporation, this payment option includes the digital presentment of three payment modalities – 1) eCheck, 2) VCC, and 3) ACH/EFT. Med-Pay is specifically targeted to Providers who have never enrolled for ACH/EFT and have opted-out of VCC. If you do not want to receive Med-Pay, be sure to sign up for EFT immediately after opting out of VCC.

Paper Check

Paper checks are available, but the Plan recommends electronic payments as they are faster and more convenient.

If you have questions regarding VCC, EFT, or Med-Pay please call Echo Health at **1-888-492-5579, option 2.**

Provider Electronic Remittance Advice (ERA)

The Provider ERA (Electronic Remittance Advice) contains detailed claims information for the payment of claims, claims adjustments, and claims interest payments to Providers. Provider ERAs include A/R detail, when appropriate, and may contain multiple PDF documents. The various payment types include spending account payment, remittance payment, and facility remittance.

Participating Providers can use the Claims Status Inquiry transaction on NaviNet® to get claim payment information for finalized claims. Through this transaction, Providers can download and/or print their Provider ERA. To access the ERA and Remittance transaction, select Claims Status Inquiry from the Workflows menu, and then conduct a search for a specific Member and date of service. Once the specific claim details are displayed, click on the link to “View ERA” in the Additional Information box. Note: Your designated Security Officer has access to the transaction, and he or she will manage access for applicable staff in your practice.

Retrospective Reviews of Claims

The Plan may conduct retrospective reviews of claims for services that did not receive prior authorization. The Plan will complete these retrospective reviews within 90 days of the date the claim is paid. The Plan may recover payments from Providers for reimbursed services determined not to be Medically Necessary.

Billing the Member

Copayments, co-insurance, and any unpaid portion of the deductible may be collected at the time of service.

Balance or Surprise Billing

Out-of-Network Providers may need to bill the Member for unpaid balance after time of service. It is the Out-of-Network Provider's responsibility to advise the Member and to obtain the Members acknowledgment in writing if products or services extend beyond the Plan's coverage so that the Member understands that they are liable for any costs beyond what the Plan will pay.

Members are protected from balance billing for:

Emergency Services

If a Member has an emergency medical condition and gets emergency services from an out-of-network Provider or facility, the most the Provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). A Member can't be balance billed for these emergency services. This includes services the Member may get after they are in stable condition unless they give written consent and give up their protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a Member gets services from an in-network hospital or ambulatory surgical center, certain Providers in those facilities may be out-of-network. In these cases, the most those Providers may bill the Member is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers can't balance bill the Member and may not ask the Member to give up their protections not to be balance billed.

Out-of-Network Providers

Out-of-Network Providers may need to bill the member for unpaid balance after time of service. It is the Out-of-Network provider's responsibility to advise the member and to obtain the members acknowledgment in writing if products or services extend beyond the Plan's coverage so that the member understands that they are liable for any costs beyond what the Plan will pay.

Utilization Management

Overview

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

We will:

- Routinely assess the effectiveness and efficiency of our utilization review program.
- Coordinate the utilization review program with our other medical management activities, including quality assurance, credentialing, Provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
- Provide covered persons and their Providers with access to our review staff via a toll-free phone number or collect call whenever any Provider is required to be available to provide services that may require prior certification or authorization to any plan Member. The department's clinical staff and medical directors are available and accessible to all Providers and Members from 8 a.m. to 8 p.m., Monday through Friday, Eastern time (ET), with the exception of company-observed holidays, by calling our toll-free number at 1-833-435-8600. Utilization Management clinical staff are available on call after normal business hours, weekends, and holidays by calling 1-833-435-8600. A toll-free fax line is available to receive inbound communications from Providers 24 hours a day, seven days a week, at 1-833-435-3290. TTY and language assistance is also available at 711.
- Limit our requests for information to only that information needed to certify or authorize the admission, procedure, treatment, length of stay, and frequency and duration of health care services.
- Provide written procedures for making utilization review decisions and notifying covered persons of those decisions.
- Have written procedures to address the failure or inability of a Provider or covered person to provide all necessary information for review. If a Provider or covered person fails to release necessary information in a timely manner, the Plan may deny certification.

We will make review decisions after all the necessary information about the requested service has been received. Within the following time frames, we will communicate our review determination, whether adverse or not, to the Provider after we obtain all necessary information about the admission, procedure, or health care service being requested, also including, but not limited to, clinical notes, clinical evaluations, and second opinions from a different clinician.

- Concurrent requests are decided and communicated within 24 hours from the date of receipt.

- Urgent care prospective requests are decided and communicated as soon as possible, considering medical needs, but will not exceed 72 hours from the date of receipt.
    - A prospective request is considered urgent if it is determined that a delay in the decision could reasonably appear to seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- Nonurgent care prospective requests are decided and communicated within 15 calendar days from the date of receipt.
- Retrospective requests are decided and communicated within 30 calendar days from the date of receipt.

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

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

If a Provider or Member fails to release necessary information in a timely manner, we may deny certification or authorization of the requested service. The decision to deny certification or authorization can be appealed.

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

- Any reduction or termination by us of such treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. We will notify the Member of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- A Member can ask to extend the course of treatment beyond the prescribed time or number of treatments. In certain situations, we will make a benefit determination as soon as possible. This is the case when a delay in the decision could reasonably appear to:
    - Seriously jeopardize the life or health of the Member.
    - Seriously jeopardize the Member's ability to regain maximum function.
    - In the opinion of a physician with knowledge of the Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the care or treatment that the Member is requesting.

In making a decision, we will take any urgent medical needs into account. As long we receive the request at least 24 hours before the expiration of the prescribed period of time or number of treatments, we will notify the Member of the benefit determination within 24 hours of receiving the request for concurrent requests

and within 72 hours for prospective requests. This is true whether the benefit determination is adverse or not. Notification of any adverse benefit determination for a request to extend the course of treatment shall be made in accordance with this plan.

If we certify or authorize a health care service, we will notify the Member's Provider. For an adverse benefit determination, we will notify the Member's Provider and send written or electronic confirmation of the adverse benefit determination to the Member. For concurrent reviews, we will be responsible for health care services until the Member has been notified of the adverse benefit determination (i.e., decertification does not become effective until notice is provided to the covered person). For retrospective reviews, we will notify the Provider in writing of our decision. If we deny the service as a result of the review, we will send written notice to both the Member and their Provider. We remain responsible for health care services until the Member has been notified of the adverse benefit determination. We will notify the Member orally or in writing.

Untimely service authorizations constitute a non-certification, and the Health Plan treats these as appealable adverse actions. An Adverse Benefit Determination is also issued if a determination or need for an extension is not communicated to the Provider within the required timeframe.

To obtain prior authorization or verify requirements for inpatient or outpatient services, including which other types of facility admissions need prior authorization, you or your Provider can call us at 1-833-435-8600.

Prior Authorization Policy and Procedure

- Applies to all services and Providers except Pharmacy Providers. Pharmacy Providers are subject to the Plan's pharmacy prior authorization processes regardless of network participation status. For information on the pharmacy prior authorization process, see the *Pharmacy* section of this manual.
- Prior authorizations with the Plan are required for certain services for participating Providers. Please refer to the **Prior Authorization Look up Tool** for services requiring prior authorization and criteria. For out of network Providers, prior authorization is required for all services except emergency services. Upon request, Providers may call 1-833-435-8600 to reach our Utilization Management Department for prior authorization criteria and education.
- A toll-free fax line is available to receive inbound communication 24 hours a day, 7 days a week. Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday-Friday are responded to on the same business day. Our staff will be able to answer questions and help assist you with your prior authorization request, including requests for inpatient hospitalizations.
- For Members new to the Plan, we will allow a Member to use an out of network Provider for medically necessary services for a period of ninety (90) days, with some exceptions, i.e., pregnancy, end of life, etc. The Member or Provider needs to notify us of existing services so they can receive prior authorization. If the Member is pregnant, and in her second or third trimester, pregnancy-related services will be covered through 60 calendar days post-partum.
- The Plan offers information on its prior authorization policies to reduce the need to recover for claims paid when the service is determined not to be Medically Necessary. Prior authorization requirements are listed in detail in this section of the *Provider Manual*.

- Determination of lack of Medical Necessity is considered an adverse action and may be appealed by the Member (or by the Provider on behalf of the Member) under certain circumstances.
- The Plan will provide comprehensive, ongoing Provider training and outreach to contracted Providers. Training will include prior authorization and billing processes to help Providers treating our Members to avoid delays in payment or Member service delivery. The training schedule can be found on the Plan website at https://www.amerihealthcaritasnext.com/fl.
- The Plan offers additional training materials on its website and these materials are accessible for both in-network and out-of-network Providers.

Prior Authorization Requests

Provider Authorization Look Up Tool

To assist Providers with prior authorization request, the Plan hosts a **Prior Authorization Look up Tool** on the Plan website. The Provider may enter a CPT/HCPCS code and will be advised if the service requires prior authorization. Providers may call Utilization Management at 1-833-435-8600 with any questions**.**

NantHealth | NaviNet® Medical Authorizations

AmeriHealth Caritas Next has worked with NantHealth | NaviNet® to bring you, Medical Authorizations, a robust, intuitive, and streamlined online authorizations workflow.

In addition to submitting and inquiring on existing Authorizations, you will also be able to:

- Verify if no authorization is required.
- Receive auto approvals, in some circumstances.
- Submit amended authorization.
- Attach supplemental documentation.
- Sign up for in-app status change notifications directly from the health plan.
- Access a multi-payer authorization log.
- Submit inpatient concurrent reviews online if you have Health Information Exchange (HIE) capabilities (fax is no longer required).
- Review inpatient admission notifications and provide supporting clinical documentation.

Video tutorials and step-by-step instructions will be available via the NaviNet® Plan Central page and the NantHealth Help Center.

AmeriHealth Caritas Next will offer training on the NaviNet® Medical Authorizations system. Contact your Provider Network Management Account Executive for available training dates and times.

Utilization Management Department Information

The Plan's Utilization Management (UM) department hours of operation are 8am – 5pm EST, Monday through Friday and can be reached at:

- UM Telephone: 1-833-435-8600.

- UM Physical Health Prior Authorization Fax: 1-833-435-3290.
- UM Behavioral Health Prior Authorization Fax: 1-833-329-3529.
- UM Physical Health Concurrent Review fax: 1-833-435-3291.
- Peer to Peer Review Telephone: 1-833-727-0990.
- Bright Start® (NICU and OB related) Telephone: 1-833-435-7708.
- Bright Start (NICU and OB related) Fax: 1-833-770-8329.
- A toll-free fax line is available to receive inbound communication 24 hours a day 7 days a week. Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday-Friday are responded to on the same business day. Our staff will be able to answer questions and help assist you with your prior authorization request, including requests for inpatient hospitalizations.

Physical Health, Behavioral Health, and Pharmacy prior authorization forms can be found on the plan website.

Physical and Behavioral Health Prior Authorizations

Certain services or supplies may need to be reviewed before the Member receives them to make sure they are medically necessary and being provided by a network Provider. If a Member is receiving services from a network Provider, the Provider will be responsible for obtaining any necessary prior authorization before they receive services. If the prior authorization is denied and the Provider still provides these services, the Provider cannot bill the Member for these denied services unless the Member agreed to receive services at a self-pay rate. If a Member is obtaining services outside of our service area or from an out-of-network Provider, the Member will need to make sure that any necessary prior authorization has been received before receiving services. If the Member does not, the service may not be covered under this plan.

Prior authorization can be retracted after emergency services are provided if the Member or your Provider materially misrepresented the Member's condition. Coverage will also depend on any limitations or exclusions for this plan, payment of premium, eligibility at the time of service, and any deductible or cost-sharing amounts. If the Provider or the Member does not obtain prior authorization before an elective admission to a hospital or certain other facilities, the Member may be responsible for all charges related to services that fail to meet prior authorization requirements.

This list of physical or behavioral health services needing prior authorization is subject to change. For the most up-to-date information, please visit the prior authorization section of the plan website.

Referrals

The Plan does not require referrals for in-network Providers.

Physical Health Services Requiring Prior Authorization:

Providers are encouraged to use the **Prior Authorization Look-up tool** on the plan website to find out if a service requires prior authorization.

- All out-of-network services excluding emergency services.

- All services that may be considered experimental and/or investigational.
- All miscellaneous services.
- Chemotherapy.
- Cochlear implantation.
- Congenital cleft lip and palate oral and facial surgery or orthodontic services.
- Dental anesthesia.
- DME:
    - All unlisted or miscellaneous items, regardless of cost.
    - DME leases or rentals and custom equipment.
    - Items with billed charges equal to or greater than $750.
    - Negative pressure wound therapy.
    - Prosthetics and custom orthotics.
- Elective air ambulance.
- Elective procedures including, but not limited to, joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, and laparoscopic or exploratory surgeries.
- First- and second-trimester terminations of pregnancy require prior authorization and are covered in the following two circumstances:
    - The Member's life would be endangered if she were to carry the pregnancy to term.
    - The pregnancy is the result of an act of rape or incest.
- Gastric restrictive procedures or surgeries.
- Gastroenterology services.
- Gender reassignment services.
- Genetic testing.
- Home-based services.
- Home health aide services.
- Home health care services — Including, but not limited to, physical therapy, occupational therapy, speech and language therapy, and skilled nursing services. Prior authorization is required after any combination of six home health care service visits are received to allow coverage for any additional home health care services.
- Home infusion services and injections
- Hospice inpatient services.
- Hyperbaric oxygen.
- Hysterectomy (Hysterectomy Consent Form required) Inpatient hospital services:

- All inpatient hospital admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation.
    - Elective transfers for inpatient and/or outpatient services between acute care facilities.
    - Medical detoxification.
    - Medically necessary contact lenses.
- Pain management including, but not limited to:
    - Epidural steroid injections.
    - External infusion pumps.
    - Implantable infusion pumps.
    - Nerve blocks.
    - Radiofrequency ablation.
    - Spinal cord neurostimulators.
- Personal care services, or help with activities of daily living including bathing, eating, dressing, toileting, and walking.
- Postmastectomy inpatient care.
- Reconstructive breast surgery (following a mastectomy).
    - Rehabilitation services and habilitative services (chiropractic services and speech and language, occupational, and physical therapy). Chiropractic services, speech and language, occupational, and physical therapy require prior authorization after initial assessment or reassessment. This applies to private and outpatient facility-based services.
- Skilled nursing care.
- Surgical services that may be considered cosmetic, including:
    - Blepharoplasty.
    - Breast reconstruction not associated with a diagnosis of breast cancer.
    - Mastectomy for gynecomastia.
    - Mastopexy.
    - Maxillofacial surgery.
    - Panniculectomy.
    - Penile prosthesis.
    - Plastic surgery/cosmetic dermatology.
    - Reduction mammoplasty.
    - Septoplasty.
- The following radiology services, when performed as outpatient services, may require prior authorization:

  - Computed tomography (CT) scan.
  - Magnetic resonance imaging (MRI).
  - Magnetic resonance angiography (MRA).
  - Nuclear cardiac imaging.
  - Positron emission tomography (PET) scan.
- Transplants, including transplant evaluations.
- Treatments provided as part of clinical trials.

Physical Health Services That Do Not Require Prior Authorization

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

The following services will not require prior authorization:

- 48-hour observation stays (except for maternity delivery and cesarean section surgery — physician notification is required).
- Electrocardiograms (EKGs).
- Dialysis.
- Family planning services.
- Low-level plain film X-rays.
- Postoperative pain management (must have a surgical procedure on the same date of service).
- Pediatric routine vision services.
- Women's health care by network Providers (OB/GYN services).
- Emergency care (in-network and out-of-network).

Behavioral Health Services Requiring Prior Authorization

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

- Psychiatric inpatient hospitalization.
- Psychological testing.

Behavioral Health Services That Do Not Require Prior Authorization

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

Diagnostic Imaging Services Provided by Evolent

The following diagnostic imaging services, when performed as an outpatient service, require prior authorization by the Plan radiology benefits vendor, Evolent:

- CT/CTA.
- CCTA.
- MRI/MRA.
- PET Scan.
- Myocardial Perfusion Imaging.
- MUGA Scan.

To request prior authorization, contact the Plan's radiology benefits vendor (Evolent) via their Provider web-portal at www.radmd.com or by calling 1-800-327-1187 Monday through Friday 8:00 a.m. – 8:00 p.m. (EST). The ordering physician is responsible for obtaining a Prior Authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by Evolent and the ordering physician should have this information available at the time of the call. Weekend, holidays, and after-hours prior authorization requests* can be submitted online. The Evolent web site is available 24 hours a day to Providers. Weekend, holiday, and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to Evolent at 1-800-327-1187 and a message may be left by voice mail at which will be retrieved the following business day.

Within one business day of retrieval of the voice mail request, Evolent will contact the Provider's office to obtain necessary demographic and clinical information to process the request.

*Evolent's hours are 8:00 a.m. – 8:00 p.m. Eastern Time, Monday through Friday, excluding holidays.

Physical Health Services That Require Notification

Providers are asked to notify the Plan within one business day of when the following services are delivered:

- All newborn deliveries including those that occur in birthing centers.
- Maternity obstetrical services (after first visit) and outpatient care (includes observation).

- Continuation of covered services rendered by an out of network Provider for a new Member transitioning to the Plan the first 90 calendar days of enrollment. The Plan will conduct a medical necessity review of services that received prior authorizations from an insurer other than the Plan.
- Inpatient admissions following emergency room medical care, emergency short procedure unit services, or an observation stay.

Providers can notify us by:

- Calling Utilization Management at 1-833-435-8600
- Physical Health Prior Authorization fax**:** 1-833-435-3290
- Behavioral Health Prior Authorization fax: 1-833-329-3529
- For admission notification, concurrent review and discharge planning: 1-833-435-3291
- For online prior authorization, Providers can also use the Medical Authorizations feature inside our secure Provider portal (NaviNet®) by going to https://www.NaviNet®.net.

Pharmacy Prior Authorization

The Plan's Pharmacy Benefit Manager, PerformRx, reviews prior authorizations for drugs on the Formulary that require prior authorization. PerformRx Pharmacy Provider Services may be contacted at 1-833-982-7977 between 8:00 a.m. and 6:00 p.m., EST excluding holidays.

Pharmacy prior authorization procedures are as follows:

The prescriber contacts the Plan by:

- Submitting a prior authorization request via the pharmacy prior authorization function in NaviNet®, or
- Faxing a completed Pharmacy prior authorization form to **1-844-470-2507**, or
- Calling Provider Services at 1-833-982-7977 for verbal prior authorization requests.

Through single sign-on to NaviNet®, you can access the Pharmacy Prior Authorization portal to:

- Check on real-time status of pharmacy prior authorization requests.
- Obtain news and announcements about pharmacy related items (formulary updates, criteria updates, etc.)
- Submit secure electronic prior authorization requests.

Pharmacy Prior Authorization Forms

Pharmacy online prior authorization forms can be found at:
https://ppa.performrx.com/PublicUser/OnlineForm/OnlineAbarcaSingleForm.aspx?cucu_id=vrRiF1UyflQOh8M9wgCQpw%3d%3d

A printable pharmacy prior authorization form can be found at:
https://www.amerihealthcaritasnext.com/fl/providers/prior-authorizations.aspx

Pharmacy Prior Authorization Decision Turnaround Times

Standard: The Plan's Pharmacy Benefit Manager (PBM), PerformRx must send decision notifications of all standard prior authorization requests within 72 business hours of receipt.

Expedited: The Plan's Pharmacy Benefit Manager (PBM), PerformRx must send decision notifications of all expedited prior authorization requests within 24 business hours of receipt.

Payment Adjustments

Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the Medical Necessity of the services provided. Additionally, payment may also be adjusted if the Member's eligibility changes between the times the authorization was issued and the service was provided.

Untimely service authorizations constitute a non-certification, and the Health Plan treats these as appealable adverse actions. An Adverse Benefit Determination is also issued if a determination or need for an extension is not communicated to the Provider within the required timeframe.

Important Definitions

Medically Necessary or Medical Necessity

The covered health services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not experimental, investigational, or for cosmetic purposes, except as allowed under Florida law.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not only for the convenience of the insured, the insured's family, or the Provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Experimental/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.

Clinical Criteria, Guidelines, and Other Resources

The Plan uses the following medical necessity criteria as guidelines for determinations related to medical necessity:

- InterQual® Level of Care Acute Adult Criteria.
- InterQual® Level of Care Acute Pediatric Criteria.
- InterQual® Level of Care Outpatient Rehabilitation and Chiropractic Criteria.
- InterQual® Home Care Criteria.
- InterQual® Care Planning Procedures Adult Criteria.
- InterQual® Care Planning Procedures Pediatric Criteria.
- InterQual® DME Criteria.
- InterQual® Level of Care Rehabilitation Criteria.
- InterQual® Level of Care Subacute and Skilled Nursing Facility Criteria.
- InterQual® Level of Care Criteria Behavioral Health Psychiatry Adult and Geriatric.
- InterQual® Level of Care Criteria Behavioral Health Psychiatry Child and Adolescent.
- American Society of Addiction Medicine (ASAM) Criteria. ASAM criteria is used to evaluate level of care (LOC) for Substance Use services.

Member Considerations

- Age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment.

Local Delivery System

- Availability of sub-acute care facilities or home care in the Plan service area for post-discharge support.
- The Plan benefits for sub-acute care facilities or home care where needed.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.
- Availability of the medically necessary behavioral health level of care.

Any request that is not addressed by, or does not meet, Medical Necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on Medical Necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the Plan's Medical Director or other designated practitioner under the clinical direction of the Medical Director.

Medical Necessity decisions made by the Plan's Medical Director or designee are based on the above definition of Medical Necessity, in conjunction with the Member's benefits, medical expertise, application of the Plan Medical Necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the Plan's Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals, or the requesting practitioner/Provider may provide input to the decision. The Plan's Medical Director or designee makes the final decision.

Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the Medical Necessity of the services provided. Additionally, payment may also be adjusted if the Member's eligibility changes between when the authorization was issued and the service was provided.

Upon request by a Member or Provider, the criteria used for Medical Necessity decision-making in general, or for a particular decision, is provided in writing by the Plan's Medical Director or designee. The Plan will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness or condition of the Member.

The Utilization Management staff and physicians involved in Medical Necessity decisions are assessed semi-annually for consistent application of review criteria. Both clinical and non-clinical staff Members are audited for adherence to policies and procedures.

Hospitalization and Outpatient Services

Emergency Care

Emergency services are 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.

Emergency services are eligible for payment in accordance with the following definition of an Emergency Medical Condition:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention could result in:

- Placing the health of an individual, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.

- Serious dysfunction of any bodily organ or part.

Under Florida law, "emergency services" include medical screening, examination, and evaluation by a physician, or, to the extent allowed by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists. If it does, the appropriate personnel will also determine the needed care, treatment, or surgery for a covered service by a physician to relieve or remove the emergency medical condition. The determination includes consideration of available hospital services.

PCP Responsibilities When Sending Members to the ER

- PCPs must provide coverage 24 hours a day, 7 days a week, for their practice.
- All ER referrals should be documented in the Member's medical record.
- Follow-up care, blood work, and repeated X-rays must be managed and appropriately referred by the PCP.

Member Responsibilities When Using the ER

- In an emergency, the Member should proceed to the nearest ER for care, regardless of the Member's physical location.
- There is no requirement for the Member to contact his or her PCP before visiting an ER. However, we encourage Members to contact their PCP before visiting an ER for guidance if the Member is unsure about whether an Emergency Medical Condition exists.
- The Member's Schedule of Benefits provides specific information on ER copayments and copayment waivers.

Follow-up Care

- Generally, follow-up care after an ER visit is considered routine care. Routine (non-emergent) follow-up care provided in the ER setting by a Provider is not a covered service. Members should not be referred back to the ER for follow-up care services if they can be referred to their PCP or network specialty Provider without medically harmful consequences.
- Examples of routine follow-up care in the ER include the following:
    - Patient returns to have a prescription extended that was written in the ER.
    - Patient returns to the ER for reapplication of bandages, splints, or wraps.
    - Patient who had a laceration repaired with sutures returns to the ER to have the sutures removed.

When follow-up care provided in the ER setting is denied as a non-covered service, Members may be billed for such non-covered services, subject to the terms of your Provider Agreement. This requires, in relevant part, that you give the Member written notice prior to providing the non-covered services indicating that follow-up care in the ER setting is not covered and that the Member will be financially responsible for such non-covered services.

Routine (non-emergent) follow-up care provided in the ER setting by a Participating Provider is not eligible for a separate ER visit payment.

Ambulatory Care

Prior authorization is required for certain outpatient procedures. Prior authorization for these procedures must be obtained at least five business days prior to the scheduled date of the procedure. Providers are responsible for obtaining prior authorization as needed.

Go to AmeriHealth Caritas Next to search for the procedure in the Prior Authorization Look-up Tool or call Utilization Management at 1-833-435-8600.

Billing Multiple Services

The Plan requires that professional claims be billed on one CMS-1500 claim form or electronic 837P transaction when two or more procedures or services were performed for the same patient, by the same performing Provider, and on the same date of service. When services rendered on the same date by the same Provider are billed on two claims, it is defined as "split-billing."

The only instances when split-billing is acceptable to the Plan are when we specifically require services to be billed on separate claims based on a Plan policy (e.g., assistant or co-surgery claims). Some examples of disallowed split-billing include:

- Two or more procedures or services performed by the same Provider, on the same date of service, on the same patient, and submitted on more than one claim form.
- Services considered included in the primary services and procedures as part of the expected services for the codes are billed on separate claim forms.

Providers must bill on one claim form for all services performed on the same day, for the same patient, unless there is a Plan policy that supports split-billing for the services or procedures performed. Failure to do so prohibits the application of all necessary edits and/or adjudication logic when processing the claim. As a result, claims may be under- or overpaid and Member liability may be under- or overstated.

If a service for which there is no policy to support split-billing is inadvertently omitted from a previously submitted claim, the original claim should be corrected.

Note: Do not submit a separate claim for the omitted services, as that will create a split-billed claim and all individually submitted claims will be adjusted to deny.

Determining Whether Procedures Are Cosmetic

The Plan requires prior authorization for procedures that are generally cosmetic in nature. Procedures that are, or may be considered to be, cosmetic can be looked up on the **Prior Authorization Look up Tool** Some of these procedures, depending on specific medical criteria, may be approved for coverage. For coverage consideration, the Provider must complete the prior authorization process.

Participating Providers should submit their requests through NaviNet® prior to services being performed. Failure to obtain prior authorization where required may lead to a denial of payment. Review the clinical policy for each potentially cosmetic procedure at AmeriHealth Caritas Next. The clinical policies contain a definition of and our coverage position for each procedure.

Skilled Nursing Facilities

Skilled nursing facility (SNF) services are covered for Members who need skilled or sub-acute care. SNF services are subject to prior authorization and may be subject to certain benefits limits.

All SNF admissions are either arranged by care management staff or prior authorized through the prior authorization process. SNF admissions are reviewed weekly or more often, if necessary, to facilitate appropriate use of benefits and to promote optimal benefits coverage.

Inpatient Hospital

Inpatient hospital benefits are available to Members and are subject to prior authorization. In the case of an urgent or emergent admission for a Member, the hospital must notify the Plan within 48 hours, or on the next business day if the 48-hour period ends after 5:00 pm Eastern Time.

The attending physician is required to obtain prior authorization for all non-urgent or non-emergent admissions.

Provider Preventable Conditions

Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions (HCACs) and Other Provider-Preventable Conditions (OPPCs), or Never Events. Inpatient acute care hospitals, ambulatory surgery centers (ASCs), physicians, and other practitioners are held accountable for Never Events. Inpatient acute care hospitals are also held accountable for HCACs and OPPCs

Health Care Acquired Conditions

The category of Health Care Acquired Conditions (HCAC) will apply to Plan inpatient hospital settings only. Under this category, the Plan does not reimburse Providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis after Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic
- Procedures Except for Pediatric and Obstetric populations

Other Provider Preventable Conditions

- Post-operative death in a normal healthy patient.
- Death/disability associated with use of contaminated drugs, devices, or biologics.
- Death/disability associated with use of device, other.
- Death/disability associated to medication error.
- Maternal death/disability with low-risk delivery.
- Death/disability associated with hypoglycemia.
- Death/disability associated with hyperbilirubinemia in neonates.

- Death/disability due to wrong oxygen or gas.

Never events:

- Surgery on a wrong body part or site.
- Wrong surgery on a patient.
- Surgery on the wrong patient.

The Plan monitors the quality and appropriateness of care provided to its Members by hospitals, clinics, physicians, home health care agencies, and other Providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan.

The Plan's goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.
- Reduce medical errors through the appropriate use of best clinical practices
- Use evidence-based medicine and health information technology under the plan or coverage
- Implement wellness and health promotion activities
- Implement activities to improve patient safety

Patient Safety Standards

In accordance with/to 45 CFR § 156.1110, when the Plan(s) contract with a hospital with greater than 50 beds, the Plan will verify that the hospital, as defined in section 1861 (e) of the Act:

(A) Utilizes a patient safety evaluation system as defined in 42 CFR 3.20; and

(B) Implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; or

(C) Implements an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination.

Potential Quality of Care Concerns

Potential quality of care concerns are fully investigated by The Plan. Quality of care (QOC) concerns will be thoroughly investigated by clinical reviewers in accordance with Plan policy. Providers are required to comply with The Plan QOC review process to include submitting records timely in accordance with our policy and procedures. Failure to provide records timely may result in sanctions.

Summaries and situational reviews are presented to the Credentialing Committee on a monthly basis. Serious QOC concerns may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan's network, sanctions, or corrective action. Referral to the QAPIC is the discretion of the Plan Medical or QM Director.

If the QAPIC investigation involves an action reportable to a national or State entity or database, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and State regulatory agencies.

The QM Department reserves the right to take any of the following actions, based on its discretion:

- Requiring the provider to submit medical records.
- Requiring the practitioner/provider to submit a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan (CAP), which may include continued monitoring by The Plan to help ensure that adverse events do not continue or recur. The CAP will be documented in writing and may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.

This requirement will be documented in writing.

In addition, the QAPIC may recommend the following:

- Implementing formal sanctions, including termination from the Plan network if the offense is deemed an immediate threat to the wellbeing of Plan members.

The Plan reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the actions listed above.

At the conclusion of the investigation, the practitioner/provider will be notified by letter of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

Provider Sanctioning Policy

It is the goal of the Plan to assure members receive quality health care services. In the event that medical or behavioral health services rendered to a member by a network provider represent a serious deviation from, or repeated noncompliance with, the Plan's quality standards, recognized treatment patterns of the organized medical community, and/or standards established by the State, the network provider may be subject to the Plan's formal sanctioning process.

Except for any applicable State licensure board reporting requirements, all sanctioning activity is strictly confidential.

Formal Sanctioning Process

Following a determination to initiate the formal sanctioning process, the Plan will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with the Plan on the proposed action.
- Reminder that the practitioner/provider has 30 calendar days following receipt of notification within which to file an appeal through the provider appeals process.
- Notification that the practitioner/provider may waive his/her right to a hearing and that the right will be considered waived if no written request for a hearing is submitted.
-

Notice of Hearing

If the provider requests a hearing in a timely manner the provider will be notified of the following in writing:

- The place, date, and time of the hearing, which will not be less than 30 days after the date of the notice.
- That the provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the Plan Market Chief Medical Officer and/or upon advice of the AmeriHealth Caritas Legal Affairs department.
- A list of witnesses (if any) expected to testify at the hearing on behalf of The Plan.

Conduct of the Hearing and Notice

The hearing will be held before a panel of individuals appointed by the Plan (the Hearing Panel), as follows:

- Individuals on the Hearing Panel will not be in direct economic competition with the practitioner/provider involved, nor will they have participated in the initial decision to propose sanctions.

- The Hearing Panel will be composed of physician members of the Plan's quality-related committees, The Plan's Chief Medical Officer and/or designee, and other physicians and administrative persons affiliated with the Plan as deemed appropriate by the Plan Chief Medical Officer, such as legal counsel.
- The Plan's Chief Medical Officer or his/her designee serves as the Hearing Officer.
- The right to the hearing will be forfeited if the practitioner/provider fails, without good cause, to appear.

Provider Hearing Rights

The provider has the right to:

- Representation by an attorney or other person of the provider's choice;
- Have a record made of the proceedings (copies of which may be obtained by the provider upon payment of reasonable charges associated with the preparation);
- Call, examine and cross-examine witnesses;
- Present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law;
- Submit a written statement at the close of the hearing;
- Receive the written recommendation(s) of the Hearing Panel within 15 working days of completion of the hearing, including statement of the basis for the Hearing Panel's recommendation(s), which will be provided by certified mail or via another means providing for evidence of receipt; and,
- Receive the Plan's written decision within 60 days of completion of the hearing, including the basis for the Plan's decision(s), which will be provided by certified mail or via another means providing for evidence of receipt.

Appeal of The Plan Decision

The provider may request an appeal after the final decision of the Plan. The practitioner/provider must submit a written appeal by certified mail or via another means providing evidence of receipt, within 30 days of the receipt of the Plan's decision; otherwise, the right to appeal is forfeited. Written appeal will be reviewed, and a decision rendered by the Plan's QAPIC within 45 days of receipt of the notice of the appeal.

Summary Actions Permitted

The following summary actions can be taken, without the need to conduct a hearing, by the President of the Plan or by the Plan's Chief Medical Officer:

- Suspension or restriction of the practitioner or provider's participation status for up to 14 days, pending an investigation to determine the need for formal sanctioning process; or,

- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any

individual. A hearing will be held within 30 days of the summary action to review the basis for continuation or termination of this action.

Specialty Programs

Radiology Services

Advanced Diagnostic Imaging Services

We have contracted with Evolent, an independent company, to perform precertification for outpatient non-emergent diagnostic imaging services and certain high-technology radiology services for our Plan Members.

Ordering Physicians -The ordering physician is responsible for obtaining a prior authorization number for the requested radiology service. Patient symptoms, past clinical history, and prior treatment information will be requested by Evolent. The ordering physician should have this information available at the time of the call.

- CT/CTA scans
- CCTA/FFR
- Echocardiography
- MRA
- MRI
- Nuclear Cardiology Services
- PET scans
- PET/CT Fusion

You can initiate precertification for these services in one of the following ways:

- Accessing Evolent's authorization tool https://www.radmd.com
- Calling Evolent at 1-800-327-1187 and speaking to a Customer Service Representative to request an authorization.

Reviews for the above services will be performed by Evolent, as the Plan designee, according to Medical Necessity criteria.

Note: If the above-listed services are being ordered as mapping and planning for surgery or are ordered as part of a guided procedure (such as a needle biopsy), the ordering Provider should call the prior authorization telephone number listed on the Member's ID card. Ordering Providers should not call Evolent under these circumstances

Review Authorized Procedure Codes and Descriptions

Providers should review the procedure codes and descriptions that have been authorized before performing the service. If the procedures billed are not those that have been authorized, or within the same procedure code grouping of the codes that have been authorized, payment for the service will be denied for "no authorization on file."

If there is a discrepancy between the procedure to be performed and the procedure that received prior authorization/approval, the performing Provider should work with both the ordering physician and Evolent to address the discrepancy and request any necessary changes to the authorization before rendering service.

Laboratory Services

If you are a Participating Provider, you may bill only for covered services that you or your staff perform. Participating Provider offices are not permitted to submit claims for services that they have ordered but that have not been rendered. Billing of laboratory services performed by a contracted or non-contracted laboratory is not reimbursable to the non-rendering Provider.

- The Plan requires you to direct Members to a participating outpatient laboratory provider for laboratory services and/or lab specimen testing, with the following exceptions:
- In an emergency.
- As otherwise required by law.

The following participating contracted laboratory for outpatient services is available:

Laboratory	Service	Phone	Website
DrugScan	General Lab Services	See website for locations and contact information	https://drugscan.com/
Quest Diagnostics	General Lab Services	See website for locations and contact information	https://www.questdiagnostics.com

Requesting Laboratory Services

When requesting laboratory services, fill out the laboratory requisition form completely, including the Member's insurance information (Member ID number, address, type of coverage, etc.), the tests you are ordering, his or her diagnosis, and the location where the reports are to be sent. This helps ensure that the laboratory claim will process properly and reduces Member billing issues.

To locate drawing stations for participating laboratories, use the Find a Provider, Pharmacy, or Drug tool at https://www.amerihealthcaritasnext.com/fl. Once on the Provider Search screen, change the location in the upper right portion of the screen to a city and state or zip code based on where the Member would like to receive services, select the "Places by Type" search box, then enter the word "Lab" or "Laboratories", and select the link for "Laboratory Services". Search results for the Labs in your area will display.

Keep in mind the following:

- PCPs may obtain a specimen in the office or send a Member to a drawing station.
- All Members sent to a drawing station must be sent with the appropriate laboratory requisition form. The requesting office should complete the appropriate laboratory requisition form. These requisition forms permit multiple Providers to receive results; the initiator must provide full names and addresses of the Providers who should receive a duplicate copy. *Note:* If the Member does not present the requisition form when his or her blood is drawn, the Member will be billed by the drawing station.

Contractual Obligation to Use Participating Providers

Participating Providers are required to refer Members only to other Participating Providers for covered services. If a Participating Provider directs Members to a nonparticipating laboratory for laboratory services and/or lab specimen testing and does not obtain prior authorization from the Plan, the ordering Provider is required to hold the Member harmless.

The ordering Provider will be responsible for any and all costs to the Member and must reimburse the Member for any such costs paid by the Member. In addition, further noncompliance may result in immediate termination of your Plan Provider Agreement.

If a Provider 1) refers a Member to a nonparticipating laboratory for non-emergent services without obtaining prior authorization from the Plan to do so; 2) sends a Member's lab specimen to a nonparticipating laboratory without prior authorization; or 3) provides or orders non-covered services for a Member, the Provider must inform the Member in advance, in writing, of the following:

- The list of the services to be provided.
- That the Plan will not pay for or be liable for the listed services.
- That the Member will be financially responsible for such services.

However, the Member is not required to agree to receive services from a non-participating laboratory (or any) Provider.

Providers should also be aware of the coverage status of the tests they order and should notify the Member in advance if a service is considered experimental/investigational or is otherwise non-covered by the Plan.

Most Cost-Effective Setting Program

The Plan wants to see that our Members receive infusion therapy drugs in the most appropriate and cost-effective setting consistent with their medical needs and conditions. The Plan reviews the most appropriate setting for our Members to receive certain infusion therapy drugs as part of the prior authorization review process.

- The settings that the Plan considers to be cost-effective are:
- An in-network Provider office.
- The Member's home.
- An in-network infusion center.

Reimbursement for administration of these drugs at an outpatient hospital facility instead of the home, an in-network infusion center, or an in-network office, is available only if the criteria outlined in our policy is met. This policy is available on the American Medical Association website at https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf.

Population Health

Overview

The Plan's Population Health program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows Members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution, the Plan delivers and coordinates care across all programs.

The Population Health program includes assessment, treatment, education and other care planning, as well as service coordination. The Population Health program also incorporates health and wellness self- management education. All Members in the Population Health program are screened for social determinants of health. The program is structured around a Member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management. The Population Health process also includes reassessing and adjusting the person-centered care plan and its goals as needed. The Population Health program uses evidence-based practice guidelines.

The Plan's Population Health team includes nurses, licensed mental health and substance use disorder professionals, Care Connectors, clinical pharmacists, Plan medical directors, PCPs, specialists, Members and caregivers, parents or guardians, and community agencies. This team works to meet our Members' needs at all levels in a proactive manner that is designed to maximize health outcomes. Our Population Health program applies to all Plan Members.

Population Health Program Components

- Below are the core components to the Plan Population Health Program:
    - Bright Start® (Maternity Management).
    - Rapid Response Outreach Team (RROT).
    - Complex Care Management (CCM) including disease management for adults and children.
    - Care Coordination.
    - Health and Wellness activities.

Bright Start® (Maternity Management)

This program is designed to assist expectant mothers by promoting healthy behaviors and helping to control risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG). As pregnant Members are identified by new Member assessments, claims data, routine Member outreach and Provider reporting; our Plan staff work to ensure that each pregnant Member is aware of the services and support offered through the Bright Start® program. For

more information and the services provided by the Bright Start program, see the **Integrating Behavioral and Physical Health Care** section of this *Provider Manual*.

Rapid Response and Outreach Team (RROT)

This team is designed to address the needs of Members in accessing needed health care by identifying and decreasing barriers to such care. The RROT also gives support to Providers and their staff, providing assistance and follow-through for Members experiencing barriers to their health care. This team performs three functions on behalf of Plan Members and Providers:

- Receiving inbound calls from Members and Providers.
- Conducting outbound outreach activities.
- Providing care coordination support.

Physicians are encouraged to call RROT at 1-833-435-7708 if they believe a Member would benefit from complex care management.

Complex Care Management (CCM)

Adults and children requiring Complex Care management can be referred to the CCM program by their practitioner. This program serves Members identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of Member-centered prioritized goals that are incorporated into the Member-centered plan of care, developed in collaboration with the Member, the Member's caregiver(s) and the Member's primary care Provider (PCP) and/or supporting service Providers when applicable with appropriate consents. Program staff includes Care Managers who are licensed registered nurses (RN) or licensed mental health or substance use disorder professionals.

Members in the Complex Care Management program are routinely screened for the following:

- All Members receive a comprehensive initial assessment that meets NCQA requirements.
- Adolescents ages 11 through 17 and adult Members aged 18 and older receive a depression screening to assess for symptoms of depression. Based on the depression score, the Member may be offered education and referred to the appropriate behavioral health services.
- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

Care Coordination

Triggered through ongoing data mining combined with in-person referrals, Care Coordination programs address Members' health care needs while assessing for and addressing social needs and barriers while providing hands-on coordination.

Providers needing care management and or care coordination for Plan Members should contact RROT at 1-833-435-7708.

Health and Wellness Activities

The Plan offers Health and Wellness education, Prevention Health reminders and on-demand symptom counseling. Reminders for preventive health services and education for health promotion-related activities and other preventive health services, along with access to the health services to address needs as they arise. The Plan connects Members with services from community-based organizations to augment covered services available under the health care benefit and to assist with social determinants of health issues. Access to community resources and programs occurs in a variety of ways:

- Community resource directory to search services available in the Member's area, including resources for shelter, food, clothing and utilities.
- Community Events: Partner with community organizations to promote health-behavior learning opportunities such as nutritional classes at local supermarkets, health screenings and educational presentations.

In addition, the Plan offers all participants self-management tools that are derived from the most recent evidence-based medicine available to ensure relevancy, accuracy, and reliability of all health directives through StayWell, a National Committee for Quality Assurance (NCQA)-certified Health and Wellness products Provider.

These interactive resources allow Members to enter specific personal information and provide immediate, individual results based on the information. These tools can assist to determine risk factors, provide guidance on health issues, recommend ways to improve health and cover topics such as:

- Healthy weight (BMI) maintenance.
- Smoking and tobacco use cessation.
- Encouraging physical activity.
- Healthy eating.
- Managing stress.
- Avoiding at-risk drinking.
- Identifying depressive symptoms.

Program Participation

Participation in Population Health programs are offered to all Plan Members, with the ability for Members to opt out upon request. Members may also self-refer into a program by contacting the Plan.

Members are initially identified upon Plan enrollment, for specific Population Health-related needs, through systematic risk stratification. The Plan systematically re-stratifies Members on a quarterly basis. Members are also identified through material and telephonic outreach by the Plan. Members are encouraged to let the Plan know if they have a chronic health condition, special health need or if they are receiving on-going care. A new Member assessment is included in the Member's welcome packet to help identify current health conditions and health care services. Based upon their responses to the initial health assessment, Members are identified for participation in the appropriate care management program.

"Let Us Know" Program

Providers are encouraged to refer Members to the Population Health Program as needs arise or are identified. If you recognize a Member with a special, chronic or complex health condition who may need the support of one of our programs, please contact the Rapid Response Outreach Team at 1-833-435-7708. Providers can also complete our "Let Us Know" Member intervention request form and fax to our Rapid Response Outreach Team at 1-833-770-8329 for Members who have missed appointments, or who may need transportation services, or further education on their treatment plan or chronic condition. This form can be downloaded from our website at https://www.amerihealthcaritasnext.com/fl.

Members are also referred to the Population Health Programs through internal Plan processes. Identified issues and diagnoses that result in a referral to the Population Health program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses).
- Risk score indicating over- or under-utilization of care and services.
- Infants receiving care in the NICU.
- Members with dual medical and behavioral health needs.
- Members with substance use disorder-related conditions.
- Members who are developmentally or cognitively challenged.
- Members with a special health care need.
- Members with polypharmacy use.
- Pregnant Members.
- Members with high trauma exposure.
- Members in need of long-term services and supports to avoid hospital or institutional admission.

Integrating Behavioral and Physical Health Care

Members with mental health and substance use disorders often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. The Plan understands that coordination of care for these Members is imperative. To meet this need, the Plan has a fully integrated Medical Management Department. Under this collaboration, the Plan's integrated platform will seamlessly coordinate Member care across the physical and behavioral health and social service areas. Additionally, AmeriHealth Caritas Next complies with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Plan staff will work with the involved primary care and behavioral health Providers to develop an integrated plan of care for Members in need of physical and behavioral health care coordination. Care Managers assure that communication between the two disciplines, Providers and organizations, occurs routinely for all Members with physical and behavioral health issues. Care Managers work to coordinate with substance use disorder Providers and community resources with the appropriate Member consent as needed. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment

planning, and Provider-to-Provider communication to continuously review and assess Member needs and update care plans as warranted.

Person-Centered Plan of Care

Through the Population Health Program, the Plan works with practitioners, Members, their natural supports, and outside agencies as appropriate to develop a person-centered plan of care for Members with special or complex health care needs. Our methodology is to empower the Member to take the lead in identifying and prioritizing their goals and interventions. The Plan's plan of care specifies mutually agreed- upon goals, Medically Necessary physical and behavioral health services, as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The person-centered plan of care also takes into account the cultural values and any special communication needs of the Member, family and/or the child. Additionally, social determinants of health as identified by the Member are addressed. Social determinants of health include factors such as socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to health care.

The Plan's care planning is based upon a comprehensive assessment of each Member's condition and needs. Each Member's care is appropriately planned with active involvement and informed consent of the Member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the Member's practitioner and standards of practice.

Through the Plan's Population Health program, the Member is assisted in accessing any support needed to maintain the plan of care. The Plan and the PCP are expected to see to it that Members and their families (as clinically appropriate) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, all available treatment options should be presented to the Member (regardless of whether the Plan provides coverage for those treatments), including the option to refuse treatment.

Member-centered plans of care for Members with special health care needs are reviewed and updated at every contact; every 12 months, at a minimum; or as determined by the Member's PCP based on the PCP's assessment of the Member's health and developmental needs. The revised plan of care is expected to be incorporated into the Member's medical record following each update.

Coordinating Care through Transitions and Discharge Planning

One of the most important functions of a health plan is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care settings such as from hospital to home or hospital to rehab.
- Changes in health status due to presentation of a new chronic, sometimes life- threatening condition.
- Temporary or permanent changes in the fulcrum of care when a patient must change from a primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition.
- Changes in a living situation to obtain more independence or because of a need for greater support.
- Caregiver and family changes.

During inpatient transitions, Members are supported through the Population Health department. Members receive outreach calls soon after discharge. These calls are strategically placed to help ensure the Member has the appropriate resources in place and that the Member schedules and keeps a follow up appointment with their Provider.

Bright Start® Maternity Program

Bright Start is a multifaceted program designed to improve the health and experience of our Plan's pregnant Members by early identification and stratification, care management based off prenatal care guidelines from the American College of Obstetrician and Gynecologist, and community partnerships. This program emphasizes the importance of prenatal and postpartum care while supporting the entire family and their educational and Social Determinants of Health (SDOH) needs. Our nurse care managers serve as a Member's single point of contact assisting with education and support on complex health care needs, care coordination and connection to obstetrical Providers.

Our Bright Start program provides prenatal education through multimodalities to promote maintenance of a healthy lifestyle during pregnancy and postpartum, including mailings, phone calls and interactive, pregnancy texting through a program called Keys to Your Care.

Encourage your Patients to Self-enroll

Enrollment of maternity Members in our Bright Start perinatal program is imperative for early outreach and improving health outcomes for moms and their infants. We ask that you inform Plan Members about the program and encourage them to call our toll-free number, 1-833-435-7708 to self-enroll. During this enrollment call, a Bright Start Care Connector will explain the program to the Member, explain their resources available, answer questions and provide useful information to help them preparing for pregnancy, delivery and parenthood.

If during subsequent prenatal visits you discover that a maternity Member has not yet self-enrolled in Bright Start, Practitioners can refer the Member to the program by completing the Membership Intervention Request Form found at https://www.amerihealthcaritasnext.com/fl You can also call 1-833-435-7708 for assistance.

Educational Materials

Bright Start® materials focus on education. Once registered, mothers-to-be will receive a welcome letter and information on how to access educational materials and join our Keys to Your Care text reminder program.

Antenatal/Antepartum Care

Targeted questions screen pregnant women for risk factors associated with depression. Your office may receive calls regarding those Members who screen positive or who are judged to be at risk during any other intervention. Obstetrical (OB) Nurse Care Managers will assist you with triage and referrals to the Member's behavioral health Provider or to emergency services as required.

The following antepartum services are available:

- Skilled nursing visits, which may include:

  - 17-alpha hydroxyprogesterone caproate injections for women who have a history of preterm delivery.
  - Self-injection techniques for insulin, heparin, and others.
  - Home blood glucose, blood pressure, and urine monitoring.
  - Betamethasone injections (initial set only, repeat injections require medical director approval).
- Nutrition consults/evaluations.
- Social service evaluations.
- Durable medical equipment (DME).

Prior authorization is required for the above services.

Postpartum programs

Bright Start Postpartum Services

Postpartum care

Postpartum home skilled nursing visits are approved when Medically Necessary. These visits must be prior authorized and include:

- Wound/incision checks and wound care as needed.
- Bilirubin checks and home phototherapy.
- Infant assessments.
- Blood pressure checks.
- IV antibiotics.
- Home physical therapy.

Lactation support coverage

Lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum periods, is covered during an inpatient maternity stay as part of an inpatient admission and through the OB postpartum visit and/or pediatrician well-baby visit.

Breast pump coverage: Bright Start associates are available for initial breast-feeding support by telephone and can evaluate the need for further assistance (e.g., community resources, lactation consultant, or OB Provider).

Hospital-grade pumps are covered under the following circumstances and when supplied by an in-network Provider:

- Detained newborn.
- Infants with feeding problems that interfere with breastfeeding (for example but not limited to; cleft palate/cleft lip).

Members can purchase one portable manual or electric breast pump, plus supplies, per pregnancy from a participating, in-network DME Provider with no Member cost-sharing.

Prior Authorization for Home Phototherapy

Prior authorization is required when ordering home phototherapy to treat jaundiced newborns. Skilled nursing visits must also be prior authorized.

Preventive health initiatives

The Population Health department offers population-based initiatives with the objective of improving patient health outcomes through adherence to nationally recommended preventive health guidelines. These initiatives use various Member and Provider reminders and tools to improve utilization of preventive health services.

Preventive Health Outreach

We promote recommended preventive services and tests to targeted Member populations. The objective of these population-based initiatives is to improve adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. We may vary the topics and timing as new evidence-based recommendations are issued for preventive screenings, immunizations, and care gaps of our managed care population. Our outreach programs include breast, cervical, and colorectal cancer screening; pediatric, adolescent, and adult immunization; and influenza and pneumococcal immunizations. We will identify missing preventive care services so that providers can address gaps in care during office visits.

Vaccine Information Statements (VIS)

A VIS is an information sheet produced by the Centers for Disease Control and Prevention (CDC), in compliance with the National Childhood Vaccine Injury Act of 1986, which requires that a VIS be used to inform vaccine recipients, or their parents, about the benefits and risks of vaccines. A VIS must be provided, prior to administration, for any vaccine that is covered under the Vaccine Injury Compensation Program. The following VIS forms must be used: DTaP, Td, MMR, polio, hepatitis B, Hib, varicella, and pneumococcal conjugate. Practitioners must also record which VIS was given, the date the VIS was given, and the VIS publication date.

For copies of VIS forms, visit the CDC website at www.cdc.gov/vaccines/pubs/VIS.

Lead Screening and Prevention

The CDC is focused on the prevention of lead exposure in children in order to eliminate dangerous lead sources in children's environments before they are exposed. They maintain that the effects of lead exposure in children cannot be corrected. Even low levels of lead in blood have been shown to affect learning disabilities and behavioral problems.

Through yearly outreach, Providers are advised to try to prevent the occurrence of blood lead levels of 5µg/dL and above in children by:

- Testing children between ages 9 and 12 months, again prior to age 24 months, and thereafter based on risk, if children have not yet been tested.
- Screening children and their family Members who have been exposed to high levels of lead or whose homes were built before 1978.

- Screening children who should be tested under their state and local health screening plan.

Health & Lifestyle Education

Plan PCPs are expected to provide Plan Members with education and information about lifestyle choices and behaviors that promote and protect good health such as smoking cessation. The Plan will support Providers in this effort by developing and distributing materials for Plan Members, from time to time and as needed to address specific health education needs.

Additionally, Plan PCPs are expected to help educate Plan Members regarding:

- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access services such as vision care, behavioral health care and substance use disorder services.
- Recommendations for self-management of health conditions and self-care strategies relevant to the Member's age, culture, and conditions.

Cultural Competency and Responsiveness

Embedded in all Plan efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our Provider networks.

Cultural Competency Terms and Definitions

Providers should be aware of the following terms and their definitions:

Cultural Competence
The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.

Culture
Defined by the CDC refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Competence
As defined by the U.S. Department of Health and Human Services, competence implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by Members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deafness and hearing impaired, sexual orientation, homelessness, and geographic location.

Cultural Responsiveness
The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Culturally and Linguistically Appropriate Practices
Seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services. (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

Individuals with Limited English Proficiency (LEP)
Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Low Literacy Proficiency (LLP)
In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write, and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

Sensory Impaired
A person who is deaf or visually impaired.

Cultural and Linguistic Requirements

Plan Providers are required to offer translation services to LEP Member's needs upon request and to accommodate Members with other sensory impairments. The Plan contracts with a competent telephonic interpreter service Provider. If you need more information on using this telephonic interpreter service, please contact Provider Services at 1-833-983-3577. Health care Providers who are unable to arrange for interpretation services for an LEP, LLP, or sensory impaired Member should contact Member Services at 1-833-999-3567 and a representative will help locate a professional interpreter to communicate in the Member's preferred language. When a Member uses the Plan's interpretation services, the Provider must sign, date and complete documentation in the medical record in a timely manner to reflect the use of services.

Additionally, Providers are strongly encouraged to follow the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as set forth by the U.S. Department of Health and Human Services, Office of Minority Health:

Principle Standard

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Communication and Language Assistance

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Additional tips to support Members with LEP and other interpretation needs include:

- Establishing written policies to provide interpretive services for Plan Members upon request.
- Routinely documenting preferred language or format, such as Braille, audio, or large type, in all Member medical records.

Enhancing Cultural Competency in Health Care Settings

The Plan encourages Providers and their staff to report their race and ethnicity, the languages they speak, and the language services available through the practice. This information can be reported when Providers do their attestation through the Council for Affordable Quality Healthcare, or CAQH.

The languages reported by Providers are published in the Provider directory so Members can easily find Providers who speak their language.

The provision of culturally appropriate care requires understanding of the social and cultural differences of the patient population served and the impact culturally appropriate care can have on patient satisfaction and adherence during a medical encounter. Cultural awareness and ongoing education are important when it comes to improving the quality of care, health outcomes, and addressing racial and ethnic disparities in culturally diverse patient populations.

Cultural Competency Training

Providers are also encouraged to complete the free eLearning cultural competency training offered by HHS Office of Minority Health titled "A Physician's Practical Guide to Culturally Competent Care." This training offers up to nine CEUs and can be accessed at: https://cccm.thinkculturalhealth.hhs.gov/.

For additional Cultural Competency resources and training, including CME offerings, please visit AmeriHealth Caritas Next. Select your state and search for "Cultural competency."

Additional Resources

- Health Resources and Services Administration: Culture, Language Health Literacy
- National Institutes of Health: Clear Communication / Cultural Competency Health Literacy Innovations™
- The Health Literacy & Plain Language Resource Guide
- The Fenway Institute, National LGBT Health Education Center
- LGBT People: An Overview
- Health Literacy Universal Precautions
- Office of Minority Health – Cultural and Linguistic Competency
- National Center for Cultural Competence

Pharmacy

Overview

The Plan strives to provide Members with high-quality and cost-effective drug coverage. Our pharmacy benefits manager, PerformRx℠, also an AmeriHealth Caritas Family of Companies affiliate, handles the administration and claims processing of the Plan prescription drug benefit. As part of our commitment to comprehensive coverage, we offer a range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The Pharmacy and Therapeutics (P&T) Committee oversees our pharmacy policies and procedures and promotes the selection of clinically appropriate, safe, effective, and economically advantageous medications for our Members. The P&T Committee objectively appraises, evaluates, and selects drugs and/or drug classes for the formulary; evaluates, analyzes, and reviews policies and procedures to ultimately educate and inform health care Providers about drug products, usage, and committee decisions; and evaluates, analyzes, and reviews protocols and procedures for the use of, and access to, non-formulary drug products. The Committee is comprised of internal and external clinical pharmacists and physicians in a variety of specialties. The P&T Committee meets on no less than a quarterly basis to review and update the formulary.

Before you prescribe drugs to Members, we recommend that you become familiar with this section. In it you will find information about our prescription drug programs, formulary, and prior authorization process.

Submit your pharmacy claims to the correct plan

Please be careful to submit your claims to the correct plan. Improper claims submission will result in payment delays.

Plan Name	AmeriHealth Caritas Florida	AmeriHealth Caritas Next	AmeriHealth Caritas VIP Care
Plan Type	Medicaid managed care plan through Florida's Statewide Medicaid Managed Care (SMMC) program	Individual and Family Health Plans both on and off the Exchange	Medicare Advantage Dual Eligible Special Needs plan (D-SNP)
RX BIN Number	600428	019595	019587
RX PCN Number	07550000	PRX02813	PRX01816

Pharmacy Provider Services Phone Number	1-844-280-9131	1-833-982-7977	1-833-350-3477

Prescription drug programs

Members with an AmeriHealth Caritas Next prescription drug benefit may have coverage through one of the programs listed in this section. Coverage for drugs is based on the Member's benefits program. The formulary is reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the marketplace. As a result, the formulary is updated throughout the year. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

- Prior Authorization Program
- Step Therapy Protocol
- Quantity Limit Program
- Generic Drug Program
- Brand Drug Program
- New-to-market drugs
- Non-Formulary Drug Program
- Specialty Drug Program

Formulary Tiers

Tier 1 - Generics
Tier 2 - Preferred Brands
Tier 3 - Non-Preferred Brands
Tier 4 - Specialty

Participating pharmacy networks

Members should take their Member ID card to a pharmacy that participates in the PerformRx network. Many retail pharmacies in the U.S. are part of this network, including large chains and independently owned pharmacies. When Members are traveling in the U.S., participating pharmacies will accept Member ID cards and dispense medications based on the Member's pharmacy benefits.

Standard and Preferred Pharmacies

Some pharmacies participate with our plan to offer lower cost-sharing to plan Members. This is known as preferred pharmacy cost-sharing. Members may fill prescriptions at either a preferred or standard pharmacy. They can save money on certain prescriptions by using a preferred pharmacy.

For a complete list of pharmacies, visit https://www.amerihealthcaritasnext.com/fl.

Drug formulary information

Look-up tools, including a printable formulary document, searchable drug list and formulary guides are available on the https://www.amerihealthcaritasnext.com/fl to help Members and providers understand their specific drug program, drug restrictions and formulary.

In addition, the most recent formulary changes can be found at https://www.amerihealthcaritasnext.com/fl.

Prescription drug guidelines

The Plan continuously monitors the effectiveness and safety of drugs and drug-prescribing patterns. Several procedures support safe prescribing patterns for our prescription drug programs, such as prior authorization, step therapy, age limits, and quantity limits.

Prior Authorization Requirements

We require prior authorization of certain covered FDA-approved drugs for specific medical conditions. The approval criteria were developed and approved by the P&T Committee and are based on information from the FDA, manufacturers, medical literature, actively practicing consultant Physicians, and pharmacists.

Using criteria approved by the P&T Committee, PerformRx evaluates requests for these drugs based on clinical data and information submitted by the prescriber and available prescription drug history. Clinical pharmacist reviews will include contraindications, dosing and length of therapy appropriateness, and evaluation of other clinical options previously used.

If the request is not approved, the drug will not be covered for your patient, and he or she will be responsible for the entire cost of the drug. If the request is approved, your patient will be charged the appropriate level of cost-sharing according to their benefit. For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, go to https://www.amerihealthcaritasnext.com/fl.

When submitting requests, it is important to complete all prior authorization forms and to promptly respond to outreach efforts when there is missing information.

Note: The list of drugs requiring prior authorization is subject to change. Changes to the list will be published as the need arises.

For pharmacy-related services, Participating Providers should request prior authorization by:

- Submitting a prior authorization request via the pharmacy prior authorization function in NaviNet®.
- Faxing a completed Pharmacy prior authorization form to 1-844-470-2507.
- Calling Provider Services at 1-833-982-7977 for verbal prior authorization requests.

Expiration of Prior Authorization

Prior authorizations will include an expiration date at the time of the approval when applicable. If your patient needs to continue the drug therapy after the expiration date, you will need to submit a new request.

Step Therapy

Step Therapy 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. Step Therapy requirements are reviewed and approved by the P&T Committee.

Step Therapy is usually automated and are applied at the point of sale. If the available historical claims for the Member meets the step requirements, then the claim will pay. If it does not, then it will require a Step Therapy Prior Authorization. PerformRx℠ evaluates requests for these drugs based on clinical data and information submitted by the prescriber and available prescription drug history. Clinical pharmacist reviews will include contraindications, dosing and length of therapy appropriateness, and evaluation of other clinical options previously used.

If the request is not approved, the drug will not be covered for your patient, and he or she will be responsible for the entire cost of the drug. If the request is approved, your patient will be charged the appropriate level of cost-sharing according to their benefit. For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, go to https://www.amerihealthcaritasnext.com/fl/index.aspx.

Age Limits

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 Member's prescription does not meet the FDA age guidelines, it will not be covered until prior authorization is obtained. To request an age limit exception, complete a general pharmacy form and fax it to 1-833-479-3329 for review. The form can be found at https://www.amerihealthcaritasnext.com/fl/index.aspx.

Quantity Limits

Quantity limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses and length of therapy of a particular drug. The various types are described below:

- Quantity over Time. This quantity limit is based on dosing guidelines over a rolling time period.
- Maximum daily dose. This quantity limit is based on maximum number of units of the drug allowed per day.
- Refill too soon. With this quantity limit, if a Member used less than 75 percent for non-controlled substances or 90 percent for controlled substances, of the total day supply dispensed, the claim will be rejected at the pharmacy. This helps to ensure that the medication is being taken in accordance with the prescribed dose and frequency of administration.
- Day Supply Limit: This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day Supply Limits apply to some classes of drugs, such as narcotics.

To determine if a covered drug for a patient has a quantity limit, call PerformRx at 1-833-982-7977. For more detailed examples of quantity limits and procedures that support safe prescribing, visit https://www.amerihealthcaritasnext.com/fl/index.aspx.

To request a quantity limit exception, complete a general pharmacy form, which can be found at https://www.amerihealthcaritasnext.com/fl/index.aspx and fax it to 1-844-470-2507 for review.

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 a Provider feels that a generic drug is not appropriate for the health condition being treated and that the brand name drug is Medically Necessary, the 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 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 a Provider feels that a formulary drug is not appropriate for the health condition being treated and that the non-formulary drug is Medically Necessary, the Provider can ask for an exception request.

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. Food and Drug Administration (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 of, 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.

Non-covered Drugs with Over-the-counter Alternatives

The Plan does not cover select prescription medications that can be bought 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, the Plan 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, the Plan does not cover them.

Please refer to the pharmacy formulary for a list of most up to date covered medications.

Appealing a Decision

If a request for prior authorization or exception results in a denial, the Member, or the Provider on the Member's behalf (with the Member's consent), may file an appeal within 180 days of receiving the denial. Both the Member and the requesting Provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that the Provider be involved to provide any additional information on the basis of the appeal. For more information about appeals, please see Member's Grievance and Appeals section of this *Provider manual*

Narrow Therapeutic Index (NTI) Drugs

The Plan 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 drugs covered at $0 Copayment

Certain preventive medications, including generic products and those brand products that do not have a generic alternative, are covered without cost-sharing with a prescription when provided by a participating retail or mail-order pharmacy.

Aspirin 81 mg to help prevent illness and death from preeclampsia in women† who are at least 12 years old, after 12 weeks of pregnancy and are at high risk for the condition.

† Female or Members capable of pregnancy.

Bowel Preparation Medicine for cleaning out the bowel before colonoscopy procedures for adults age 45 through 75. Colonoscopies screen for colon and rectal cancers.
Fluoride Supplements to help prevent cavities (dental caries) in children five years or younger whose water is low in fluoride.

Folic Acid 400 to 800 mg Supplements to help prevent birth defects in women† age 55 or younger who are planning to become pregnant or can become pregnant

Low to Moderate intensity Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 to 75 who are at risk.

Tobacco Cessation Products to help adults who are not pregnant quit tobacco use to prevent health problems. Tobacco use includes smoking or chewing tobacco.

- Nicotine gum
- Nicotine lozenge
- Nicotine patch
- Bupropion hcl (smoking deterrent) tab ER 12hr 150 mg

Varenicline tartrate
Vaccines (Immunizations) to prevent certain illnesses in people of all ages recommended by Advisory Committee on Immunization Practices (ACIP).

Antiretroviral therapy for preexposure prophylaxis (PrEP) of human immunodeficiency virus (HIV) infection in people who are at an increased risk.

- Descovy (emtricitabine/tenofovir alafenamide 200 mg-25 mg), oral tablet
- emtricitabine/tenofovir DF 200 mg- 300 mg, oral tablet

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Mandated by the Women's Prevention Services provision of the Affordable Care Act (ACA), contraceptives are covered at 100 percent when prescribed by a Participating Network Provider for generic products and for those brand products that do not have a generic alternative. Brand contraceptive products with a generic alternative or generic equivalent are covered at the brand-name level of cost-sharing for the Member's plan.*

Contraceptive categories include:

- Oral contraceptives.
- Injectable contraceptives.
- Barrier Methods (Rx).
- Intrauterine Devices, Subdermal Rods and Vaginal Rings (Rx).
- Transdermal Patches (Rx).
- Emergency Contraception (Rx or OTC).
- Condoms (OTC).
- Female Condoms (OTC).
- Vaginal pH Modulators (Rx).
- Vaginal Sponge (OTC).
- Spermicides (OTC).

*Please see the Formulary for the most up to date list of products
Note: A prescription is required for all listed medications, including over-the-counter (OTC) medications.

Women's Health Preventive Services:
Breast Cancer Prevention Primary prevention of breast cancer in women 35 years of age and older, who are at an increased risk.

Breast cancer prevention products (Rx):

- Anastrozole tab 1 mg.
- Exemestane tab 25 mg.
- Raloxifene HCl tab 60 mg.
- Tamoxifen citrate tab 10 mg and 20 mg.

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 such approval has not been granted at the time of their use or proposed use or 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*.
- Mifepristone (Mifeprex)*.
- 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, once 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.
- Unit Dose products.

* Certain drugs may be covered as a non-pharmacy benefit, e.g., infused or injected drugs, which are covered under the medical Benefits.

Specialty Drug Services

Some medications are considered specialty drugs and must be obtained at a specialty pharmacy. AmeriHealth Caritas Next provides specialty drug services through a variety of designated in-network specialty pharmacies including CVS Specialty, AllianceRx Walgreens, and PerformSpecialty®, our own specialty pharmacy that is part of the AmeriHealth Caritas Family of Companies. These pharmacies specialize in providing medications used to treat certain conditions and are staffed with clinicians to provide support services and education for Members. Please use our online pharmacy locator tool to search for a participating specialty pharmacy.

Medications may be added to our specialty drug program from time to time. Our in-network 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 their Provider's office in certain cases. Although this program supplies medication to the Member via mail delivery, this is NOT part of the pharmacy mail-order plan benefit. Extended-day supplies and copayment savings do not apply to designated specialty drugs.

PerformSpecialty® Pharmacy is our network specialty pharmacy that is also part of the AmeriHealth Caritas Family of Companies. Through this program, specialty injectables and specialty oral medications that are covered under the pharmacy benefit can be shipped directly to your patients.

When using PerformSpecialty to fulfill our Members' specialty medication needs, keep in mind the following:

- Quantities for specialty injectables and specialty oral medications will be evaluated to promote appropriate prescribing. In addition, medications obtained through this program may be subject to the Member's benefits exclusions and review of Medical Necessity.
- Refills will be coordinated without additional paperwork.

Participating Providers can request fulfillment of specialty pharmacy drugs through PerformSpecialty. PerformSpecialty supplies specialty drugs eligible under the Plan's Member's prescription drug benefit administered by PerformRx.

Benefits of using PerformSpecialty include refill reminders, ongoing patient education and support, consultation with pharmacists for Providers and Members, and confidential and convenient ordering and delivery.

Providers who are considering beginning a Plan Member on a new specialty drug therapy covered under the pharmacy benefit can call PerformSpecialty to have a prescription filled at 1-855-287-7888 or by visiting the PerformSpecialty website at performspecialty.com.

Self-injectable Drugs

Most self-injectable drugs are covered under the pharmacy benefit. However, injectables that cannot be administered without medical supervision, that are required by law to be covered as a medical benefit, or that are required for emergency treatment, will continue to be covered under the medical benefit at the appropriate level of cost-sharing.

Plan Quality Management

Overview

We consider our relationship with our network Providers a partnership because we share a common goal in improving the quality of the care our Members receive. Our role is to assist Providers in providing care to our Members, and to provide the tools and information they need to maintain a high standard of care. Our Quality Management (QM) department was developed according to this mission.

QM Program Goals and Objectives

The overall goal of the QM program is to improve the health outcomes, quality and safety of physical and behavioral health care and services provided to Members by establishing a comprehensive quality management structure and program that:

- Improves access to care and quality of services provided to Members.
- Reduces health care disparities.
- Addresses medical, behavioral and, psychosocial and functional as well as unmet resource needs of the Membership.
- Assures Member satisfaction with services.
- Reviews utilization trends and establishes expectations and thresholds.
- Efficiently collects, analyzes and reports data.
- Implements strategies to manage risk.

The objectives of the QM program are to systematically develop, monitor, assess and take action to improve access to care, quality and appropriateness of care, and quality of services for all Members, including those with special health care needs through the following mechanisms and activities:

- Maximizing utilization of collected information about the quality of clinical care, physical and behavioral health outcomes and service, and identifying clinical and service improvement initiatives for targeted interventions.
- Validating adequate physical health, behavioral health and delegated service practitioner and Provider availability, accessibility and diversity to effectively serve the Membership.

- Maintaining timely and thorough credentialing/re-credentialing processes so that the health plan's network is comprised of qualified practitioners.
- Overseeing the provision of quality services by Delegated Entities providing services on behalf of the Plan.

Communicating priorities and performance status to participating practitioners through Provider profiling and information dissemination.

- Coordinating services between various settings and levels of care, network practitioners, and community resources to enable continuity of care and promote optimal physical, psychosocial (healthy opportunities/SDOH) and functional wellness and address unmet resource needs.
- Designing and implementing programs to coordinate care and maximize health outcomes for Members with complex and/or special health needs.
- Optimizing utilization management so that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with contractual, regulatory and accrediting agency standards.
- Employing assessments and interventions to identify and correct over-, under- and mis-utilization of Member benefits and services.
- Utilizing results from Member and practitioner/Provider satisfaction measures when identifying and prioritizing quality activities.
- Implementing and evaluating local, regional, and national programs and community partnerships to effectively address chronic illnesses affecting the Membership.
- Designing and implementing outreach and health education activities that lead to healthy lifestyles.
- Maintaining compliance with evolving NCQA accreditation standards.
- Communicating results of clinical, physical, behavioral, and service measures and quality initiatives to practitioners, Providers and Members.
- Identifying and implementing activities that promote Member safety in the least-restrictive environment.
- Documenting and reporting monitoring activities (internal and delegated) to appropriate committees.
- Analyzing data, including SDOH, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Members.
- Facilitating the delivery of culturally competent health care to reduce health care disparities and inequities.
- Coordinating care and transitions of care for Members who receive multiple services, whose benefits end, and during transitions from pediatric to adult care.
- Evaluating the effectiveness of the QM Program.

QM Program Activities

Through our QM Program, we monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to Members by Participating Practitioners/Providers and by delegates. We identify meaningful clinical and service issues that are likely to impact enrolled Members and establish performance indicators, goals, and benchmarks that correspond to topics falling within the scope of the QM Program.

The mechanisms used to identify meaningful clinical and service issues include, but are not limited to:

- The results of analysis of demographics, claims, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions.
- The results of data from internal performance monitoring activities and satisfaction survey results.
- Data from complaints and appeals and direct input from Members, Providers, and Plan staff.

Through ongoing review of performance data* with respect to established goals, benchmarks, and formal annual evaluations of the effectiveness of the QM Program, the Plan confirms that existing clinical quality, network, and service improvement initiatives remain appropriate and identifies new topics for inclusion in the program.

**Providers must allow the Plan to use performance data in plan QM Programs for internal purposes only.*

Member Safety Activities

The Quality Management department is responsible for coordinating activities and programs designed to improve processes and systems that promote Member safety. Initiatives focus on promoting Member knowledge about medications, home safety, and hospital safety. Activities may include but are not limited to the following:

- Member newsletter articles that improve knowledge about clinical safety and facilitate informed decisions based on safety at least biannually.
- Community service programs are used to raise awareness regarding Member safety.
- Concurrent review and care management teams assess Members during screenings for potential safety issues.
- Complaint/grievance and satisfaction data as well as potential quality of care cases are reviewed by the Quality Management Department staff to identify systems issues that may contribute to inadequate Member safety.
- Proactive follow-up systems to facilitate timely receipt of care for complex care management and disease management programs.
- Address discrepancies between clinical performance and practice guidelines.
- Improve continuity and coordination of care between practitioners or sites of care to avoid miscommunication or delays in care that can lead to poor outcomes.
- Track and trend adverse-event reporting to identify systems issues that contribute to inadequate safety.

Member Grievance Process

The QM department investigates all quality-of-care and service concerns/complaints. All quality-of-care and service concerns/complaints are triaged, categorized, analyzed, and reported on a semi-annual basis. Recommendations are used for Provider improvement activities. Complaints are also reviewed from a quarterly, as well as a rolling year, perspective for identification, and analysis of potential Provider outliers. An outlier is defined as a practitioner, facility, ancillary Provider, or pharmacy Provider against whom there are three or more complaints or a complaint that is assigned a severity level of two or higher. Members may file a concern/complaint by calling Member Services at the number listed on their ID card, by sending their complaint in writing to us at:

AmeriHealth Caritas Next
Member Grievances
P.O. Box 7450
London, KY 40742-7450

Monitoring of Continuity and Coordination of Care

The Plan annually monitors and takes action, as necessary, to improve continuity and coordination of care between care settings across the health care network, for all populations served and uses information at its disposal to facilitate continuity and coordination of medical and behavioral health care across its delivery system. Opportunities for improvement are identified and interventions are implemented to improve coordination of care across these different settings.

Continuity and coordination of care services is the facilitation, across transitions and settings of care, to facilitate:

- Patients getting the care or services they need,
- Providers getting the information they need to provide the care patients need.

Transitions in care refers to Members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. This may include movement of Members between practitioners (e.g., primary care and specialists, behavioral health practitioner and primary care), and movement across settings of care (e.g., hospital to skilled nursing facility).

Our goal is for Members to receive seamless, continuous, and appropriate care. On an annual basis, we collect data about the coordination of care across settings or transitions in care. Data is also collected related to the coordination between medical and behavioral health care. A quantitative and causal analysis of data is conducted to facilitate the identification of improvement opportunities. Based on the results of the analysis, we identify opportunities to improve continuity and/or coordination of care and implement appropriate initiatives to address opportunities for improvement.

Examples of different settings include:

- Outpatient facilities: rehabilitation centers, Physician offices, surgery centers, urgent care centers, Emergency centers, home health, and hospice,
- Inpatient facilities: hospitals (acute or rehab), skilled nursing facilities, extended care facilities, and inpatient hospice.

Open lines of communication between medical and behavioral health Providers is critical to the effective management of a Member's clinical care. Examples of the type of data collected to improve coordination of care and promote collaboration between medical and behavioral health care include:

- Exchange of information.
- Appropriate diagnosis, treatment, and referral (when required) of behavioral health disorders commonly seen in primary care.
- Appropriate use of psychopharmacological medications.
- Management of treatment access and follow-up for Members with co-existing medical and behavioral health disorders, including Members with severe or persistent mental illness.
- Primary and secondary preventive behavioral health programs.

Examples of the type of data collected to promote the identification of improvement opportunities and facilitate the design and implementation of improvement initiatives include:

- Healthcare Effectiveness Data and Information Set (HEDIS®) data for management of certain conditions and medications.

The QM department works with the Plan's Population Health department to monitor the coordination of the care of Members when they move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions often result in poor quality care and risks to patient safety.

Practitioner Credentialing and Re-Credentialing

Practitioners requiring credentialing and re-credentialing include, but may not be limited to, the list below:

- Advanced Practice Registered Nurse (APRN).
- Advanced Practice Nurse (APN).
- Behavioral Analyst (BCBA/BCABA).
- Certified Nurse Midwife (CNM).
- Certified Nurse Practitioner (CNP)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA).
- Doctor of Audiology (AuD).
- Doctor of Chiropractic (DC).
- Doctor of Osteopathic Medicine (DO).
- Doctor of Podiatric Medicine (DPM).
- Doctor of Psychology (PsyD).
- Independently Practicing Licensed Psychologist.
- Licensed Addiction Counselor (LAC)

- Licensed Clinical Social Worker (LCSW).
- Licensed Marriage and Family Therapist (LMFT).
- Licensed Clinical Professional Counselor (LCPC).
- Medical Doctor (MD).
- Optometrist who provides care under the medical benefit (OD).
- Physician Assistant (PA)
- Registered Dietician (RD).

Practitioners Who Do Not Need to Be Credentialed

- Practitioners who practice exclusively in an inpatient setting and provide care for organization Members only because Members are directed to the hospital or another inpatient setting.
- Practitioners who practice exclusively in free-standing facilities and provide care for organization Members only because Members are directed to the facility.
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.
- Covering practitioners (e.g., locum tenens).
- Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.
- Practitioners who do not provide care for Members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).
- Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

Council for Affordable Quality Healthcare (CAQH) and Online Credentialing

The Plan works with the Council for Affordable Quality Healthcare (CAQH) to offer Providers a universal Provider data source that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, practitioners submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. There is no charge to practitioners to participate and to submit CAQH applications. Practitioners not already enrolled are able to register for CAQH at https://www.caqh.org.

We strongly encourage each practitioner to participate with Council for Affordable Quality Healthcare (CAQH). Each practitioner must approve the Plan to pull the credentialing application from CAQH. Through CAQH, each practitioner determines what entity is eligible to receive his or her credentialing information.

Practitioners who have elected "universal" status need not do anything in order for the Plan to receive their information. If you do not have broad distribution permissions, please select AmeriHealth Caritas Family of Companies or AmeriHealth Caritas Next for us to receive your application.

Practitioners participating with CAQH or those who wish to participate with CAQH:

- Register for CAQH at https://www.caqh.org.
- Grant authorization to your Account Executive to view your information for AmeriHealth Caritas Next via the CAQH website https://www.caqh.org.

Individual Practitioner Application

For individual practitioners who choose not to enroll in CAQH, the application process requires submission of a completed application. The application must include evidence, such as copies of diplomas, licenses, insurance riders, and documentation of privileges. Contact your Account Executive for more information on credentialing.

Individual Practitioner Credentialing and Re-Credentialing

The following criteria must be met as applicable, in order to evaluate a qualified health care practitioner:

- Current, active, unrestrictive medical licensure, not subject to probation, proctoring requirements or disciplinary action to specialty. A copy of the license must be submitted along with the application.
- Current, active, unrestrictive DEA license, if applicable (DEA licenses are not transferrable by location and must contain the address where the practitioner is treating Plan Members).
- Evidence of professional liability insurance with limits of liability commensurate with State requirements.
- Individual NPI Number.
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the Provider and documented in the following sources:
    - The National Practitioner Data Bank (NPDB).
    - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
    - Federation of Chiropractic Licensing Boards (CIN-BAD).
    - System for Award Management (SAM)/EPPLS.
    - Social Security Death Master File.
    - Any other relevant State sanction and licensure databases as applicable.
- Proof of the Provider's medical school graduation, completion of residency and other postgraduate training.
- ECFMG Certificate for foreign medical school graduates.
- Evidence of specialty board certification, if applicable.
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Practitioner in the past five years.
- Work history containing current employment over the past years, as well as explanation of any gaps in work history.
- CLIA Certificate, if applicable.
- Explanation to any affirmative answers to the Disclosure Questions on the application.

- Practitioners who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with the Plan. PCPs must have the ability to admit Plan Members as part of their hospital privileges. As an alternative, those practitioners who do not have hospital privileges may enter into an admitting arrangement agreement with a participating practitioner who is able to admit.

All practitioners are re-credentialed at a minimum of every 36 months. All items noted above under Credentialing, with the exception of education and work history, are also required at the time of re-credentialing.

All applications and attestation/release forms must be signed and dated within 305 days prior to the Credentialing Committee or Medical Director Approval date. Additionally, all supporting documents must be current at the time of the decision date.

As part of the initial and re-credentialing application process for individual practitioners, the Plan will:

- Request information on practitioner and Provider sanctions prior to making a credentialing or re-credentialing decision. Information from the National Practitioner Data Bank (NPDB), HHS Office of Inspector general (Medicaid/Medicare exclusions), system for Award management (SAM), Federation of Chiropractic Licensing Boards (CIN-BAD), Social Security Death Master File (SSDMF), and Excluded Parties List (EPLS) will be reviewed as applicable.
- Perform primary source verification on required items submitted with the application as required by NCQA, State, and Federal regulatory bodies.
- Performance review of complaints, quality of care issues, and utilization issues will be reviewed at the time of re-credentialing.
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing.
- Safeguard all credentialing and re-credentialing documents by storing them in a secure location, only accessed by authorized Plan employees.
- Make outreach attempts to applicants via phone or email regarding information missing from the application packet. The credentialing process is halted until all information is received.

Presentation to the Medical Director or Credentialing Committee

During the initial and re-credentialing process for individual practitioners, upon receipt of a complete application and completion of primary source verifications, the practitioner's file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

The Plan will notify applicants of its recommendation in accordance with state and federal regulations. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (except for NPDB reports and peer references).

Professional Provider Organization and Facility Application Process

Facility and professional Provider organizations must complete a facility application. The following types of organizations are considered facilities:

- Ambulatory Surgical Center (ASC).
- Community-Based Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).
- Community Mental Health (CMH) Center/CMH Program/CMH Provider.
- Comprehensive Outpatient Rehabilitation Facility (CORF).
- Dialysis Center.
- Durable Medical Equipment (DME)/Medical Supplies.
- FQHC/RHC for behavioral health care only.
- Free Standing Radiology Center.
- Home Health Agency/Home Health Hospice.
- Hospice.
- Hospital.
- Portable X-Ray Suppliers/Imaging Center.
- Psychiatric Hospital.
- Psychiatric Residential Treatment Facility (PRTF).
- Rehabilitative Agency.
- Residential Care Facility.
- Residential SUD Treatment Program.
- School-Based Wellness Center.
- Screening Center.
- Skilled Nursing Facility (SNF).
- Sleep Center/Sleep Lab.

Contact your Account Executive for credentialing documents or call Provider Services at 1-833-983-3577.

Credentialing/Re-Credentialing for Facility and Professional Provider Organizations

The Plan verifies credentialing and re-credentialing criteria for all facility and professional Provider organizations. Re-credentialing occurs at least every 36 months. Facility and professional Provider organization Providers must meet the following criteria:

- Facility application with signature and current date from the appropriate facility officer.
- Attest to the accuracy and completeness of the information submitted to the Plan.

- Documentation of any history of disciplinary actions, loss or limitation of license, or loss, limitation, or cancellation of professional liability insurance.
- Current, active, unrestrictive facility licensure not subject to probation, suspension, or other disciplinary action limits.
- The Plan will confirm that the facility is in good standing with all State and regulatory bodies and has been reviewed by an accredited body as applicable.
- Current accreditation with a Plan recognized accrediting body, if applicable. If not accredited, a CMS State Survey is required. If the Provider does not have either accreditation or a CMS State Survey, a Plan Site Visit must be conducted.
- Evidence of professional liability insurance with limits of liability commensurate with State requirements.
- Group NPI Number.
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the Provider and documented in the following sources:
    - The National Provider Data Bank (NPDB).
    - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
    - System for Award Management (SAM).
    - Excluded Parties List (EPLS).
    - Any other relevant State sanction and licensure databases as applicable.

Delegated Credentialing

It is the QAPI's responsibility to oversee delegated activities. The Plan delegates credentialing to entities with more than 100 Providers. Prior to joining into a delegation agreement, a pre-delegation audit is completed. The Plan will review policies and procedures, files, and Credentialing Committee minutes to determine compliance. Annual audits are completed once we have a signed contract. Monthly rosters are submitted by the delegate for new or terminated Providers. Semi Annual full rosters are submitted by the delegate as required by NCQA.

Adding a New Service or Site

Facility Providers who are adding a new service must complete Part II of the initial credentialing application and submit it with required attachments to the attention of their designated Account Executive. The Account Executive will notify the Provider if a site visit is necessary. Facility Providers who are adding a new site must submit an application and supporting documentation to Credentialing for that new site to be credentialed.

Presentation to the Medical Director or Credentialing Committee

Upon receipt of a complete application and completion of primary source verifications, the Provider's file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

The Plan will notify applicants of its recommendation in accordance with state and federal regulations. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Re-credentialing involves periodic review and reverification of credentials of network Providers. The credentialing database houses all Provider information and a report is run to ensure each Provider organization, facility, and practitioner is re-credentialed at a minimum of every 36 months. As part of this process, the Plan periodically reviews Provider information from the following databases:

- National Provider Data Bank (NPDB).
- The Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
- Medicaid and Medicare Exclusions System for Award Management (SAM).
- Excluded Parties List (EPLS).

Providers are required to disclose, at the time of discovery, any criminal convictions of staff Members related to the delivery of health care or services. Information must also be reported at the time of application for or renewal of network participation (credentialing and re-credentialing).

Providers are also obligated to provide such information to the Plan at any time upon request.

The re-credentialing process includes an up-to-date re-examination of all materials.

Practitioner Credentialing Rights

The criteria, verification methodology and processes used by the Plan are designed to credential and re-credential practitioners and Providers in a non-discriminatory manner, regardless of race, ethnic/national identity, gender, age, sexual orientation, specialty, or procedures performed.

During the review of the credentialing application, applicants are entitled to certain rights as listed below. Every applicant has the right to:

- Review the information submitted to support their credentialing application, except for recommendations, and peer-protected information obtained by the Plan.
- Correct erroneous information. When information is obtained by the Provider Services Department that varies substantially from the information the Provider provided, the Provider Services Department will notify the health care Provider to correct the discrepancy.
- Corrections are to be made within 10 business days of identification. Providers can call Provider Services at 1-833-983-3577 for instructions on where to submit corrections.
- Upon request, to be informed of the status of their credentialing or re-credentialing application. The Provider Services department will share all information with the Provider except for references, recommendations, or peer-review protected information (e.g., information received from the National

Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Provider Services Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the Provider.

- Be notified within 60 calendar days of the Credentialing Committee or Medical Director Review decision.
- Appeal any re-credentialing denial within 30 calendar days of receiving written notification of the decision.
- Upon written request from the health care professional to the Provider Services department, all credentialing application and primary source verification policies and procedures will be made available for review.

To request any of the above, the practitioner should contact the plan Provider Services department at **1-833-983-3577**.

Site Visits Resulting from Receipt of a Complaint and/or Ongoing Monitoring

- The Provider Network Management department may identify the need for a site visit due to receipt of a Member complaint regarding the Provider's office environment.
- At the discretion of the Plan, a site visit may occur to address the specific issue(s) raised by a Member. Follow-up site visits are conducted as necessary.
- For on-site reviews occurring due to a Member complaint, the on-site review must demonstrate that the practitioner meets the Plan's quality, privacy, and record keeping standards.
- If the Plan standards are not met, the Account Executive, in conjunction with the office representative, develops, an individualized written corrective action plan (CAP) with the practitioner's office to ensure that the area of concern is addressed. The representative from the practitioner's office reviews and indicates acceptance by signing and dating the CAP.

Follow-Up Procedure for Initial Deficiencies

- The Provider Network Account Executive must submit the signed corrective action plan (CAP) to the Plan within one week of the visit.
- Each follow-up contact and visit is documented in the Provider's electronic file.
- The Provider Network Account Executive schedules a re-evaluation visit with the Provider office within 30 days of the initial site visit to review the site and verify that the deficiencies identified in the CAP were corrected.
- The Provider Network Account Executive reviews the results of the follow-up visit (including a re-review of previous deficiencies) with the office contact person.
- If the site meets and/or exceeds Plan standards, a Site Visit Evaluation Form is signed and dated by both the Provider Network Account Executive and the office. This indicates successful completion of the CAP.
- If the site does not meet Plan standards, the Provider Network Account Executive follows the procedure outlined below for Follow-Up Procedure for Continued or Secondary Deficiencies, below.

Follow-Up Procedure for Continued or Secondary Deficiencies

- The Provider Network Account Executive will re-evaluate the site monthly, up to three times (from the first site visit date).
- If, after four months, there is evidence that the deficiency is not being corrected or completed, the office will receive a failing score unless there are extenuating circumstances.
- Continued failure to correct identified deficiencies addressed in the CAP will result in appropriate disciplinary action, including and up to termination of the Provider's participation in the network.

Provider termination

Providers must make a good faith effort to provide written notice of discontinuation of a Provider 60 days prior to the effective date of the change or otherwise as soon as practicable, to Members who are patients seen on a regular basis by the Provider or who receive primary care from the Provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

Provider termination with cause

We may terminate the Professional Provider Agreement immediately upon notice to the Provider in accordance with the Agreement for cause including, but not limited to:

- Provider's violation of any applicable law, rule, or regulation.
- Provider's failure to meet and maintain our credentialing requirements including, but not limited to, maintaining the requisite professional liability insurance coverage.
- Provider action that, in our reasonable judgment, constitutes gross misconduct.
- Provider action that we determine places the health, safety, or welfare of any Member in jeopardy.
- Repeated violation of the Provider's non-discrimination obligations arising under the Agreement.
- Closure or cessation of the Provider's practice.
- Any actions by the Provider seeking bankruptcy or insolvency protection.

We will not sanction, terminate, or fail to renew a Provider's participation for any of the following reasons:

- Discussing the process that we, or any entity contracting with us, use or propose to use to deny payment for a health care service.
- Advocating for Medically Necessary and appropriate care with or on behalf of Members, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations, or tests.
- Discussing our decision to deny payment for a health care service.
- Filing a grievance on behalf of, and with the written consent of, a Member or helping a Member file a grievance.
- Any reason that is otherwise prohibited by Florida law.

Participating Provider Office Standards

Access and Availability Standards

The Quality Management (QM) department, in collaboration with Provider Network Management, establishes an annual access and availability plan to address the sufficiency of the Plan's Provider network in number, type, and geographic location of practitioners who practice primary and specialty care, in accordance with relevant regulatory and accreditation standards. The cultural needs of the Plan Members are taken into consideration, and mechanisms are implemented to provide adequate access to primary and specialty care practitioners. Availability of practitioners is assessed annually by the Provider Network Management department.

Through the Qualified Health Plan (QHP) Member Experience survey, the QM Program also establishes and measures the accessibility of services, such as regular and routine appointments, urgent care appointments, after-hours care, emergent care, and access to customer service.

We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Access standards for PCPs and specialists are as follows:

Appointment availability

PCPs

- Emergent/immediate – Twenty-four (24) hours per day, seven (7) days per week
- Urgent – One (1) calendar day
- Routine and Regular (Well or Preventive) Care - Four (4) to six (6) weeks

Specialists/Chiropractors/Podiatrists

- Emergent/immediate – Members should call 911, or go to the nearest emergency room.
- Urgent – One (1) calendar day
- Routine – Thirty (30) calendar days
- OB/GYN routine – Thirty (30) calendar days

Mental Health Providers (Non-Medication Prescribers and Medication Prescribers)

- Emergency - Within fifteen (15) minutes of presentation at a service delivery site
- Urgent, non-emergency - Within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or the Contractor.
- Non-life threatening emergency - Within 6 hours
- Routine Mental Health Services (In Follow-Up to Intake Assessment and Upon Determination) - Twenty-one (21) calendar days of the request for an appointment
- Initial Visit for routine care - Within 10 business days

Internal Waiting Time

Patients should be seen within 30 minutes from the time of the scheduled appointment.

Availability

Coverage must be provided 24 hours per day, 7 days per week, for our Members.

Covering practitioner must be a Participating Provider. Providers who use answering machines for after-hours service are required to include:

- Urgent/emergent instructions as the first point of instruction.
- Information on contacting a covering Provider.
- Telephone number for after-hours Provider access.

After-hours Phone Response

For an urgent/emergent problem, Provider should respond within 30 minutes. Auto-response messages should direct callers with emergent needs to dial 911 or go to their nearest emergency room.

Member Rights and Responsibilities

Member Rights

A Member has the right to:

- Receive information about the health plan, its benefits, services, included or excluded, from coverage policies, and network Providers' and Members' rights and responsibilities. Written and web-based information provided to the Member must be readable and easily understood.
- Be treated with respect and be recognized for their dignity and right to privacy.
- Participate in decision-making with Providers about their health care. This right includes candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. The Member has a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations about our Member rights and responsibilities policies by contacting Member Services.
- Choose Providers, within the limits of the Provider network, including the right to refuse care from specific Providers.
- Have confidential treatment of personally identifiable health or medical information; the Member also has the right to have access to their medical record per applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation,

and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.

- Formulate advance directives. The plan will provide information concerning advance directives to Members and Providers and will support Members through our medical record-keeping policies.
- Obtain a current directory of network Providers, on request. The directory includes addresses, phone numbers, and a listing of Providers who speak languages other than English.
- File a complaint or appeal about the health plan or care provided with the applicable regulatory agency and receive an answer from the health benefit plan to those complaints within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. The Member also has the right to know that their Provider cannot be penalized for filing a complaint or appeal on the Member's behalf.
- Members with chronic disabilities have the right to obtain help and referrals to Providers who are experienced in treating their disabilities.
- Have candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage, in terms that the Member understands. This includes an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the Member is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the Member's medical record. The plan does not direct Providers to restrict information regarding treatment options.
- Have available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency medical conditions.
- Call 911 in a potentially life-threatening situation without prior approval from the plan, and to have the plan pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a Provider who has been terminated from the plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the Provider is terminated for reasons that would endanger the Member, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to Members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands.
- Receive prompt notification of terminations or changes in benefits, services, or the Provider network.
- Have a choice of specialists among network Providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Member Responsibilities

A Member has the responsibility to:

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

Medical Record Requirements

Participating Providers must maintain medical records in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates easy access, availability, confidentiality and organization of records at all times. Additionally, staff receives periodic training in member confidentiality practices.

Providers must retain all medical records, whether electronic or paper, for a period of no less than 10 years after the rendering of covered services to the Member.

Providers are required to make medical records readily accessible to all appropriate government agencies, including but not limited to the Florida Department of Insurance (FLOIR), and their respective designees for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with applicable laws.

Providers must follow the medical record standards outlined below, for each Member's medical record, as appropriate:

- Each Provider furnishing services to Members is required to maintain and share with other PCPs, specialists, and behavioral health Providers as appropriate, a Member health record in accordance with professional standards and state and federal law.
- Elements in the medical record are organized in a consistent manner and the records must be kept secure, allowing access only by authorized staff.
- Patient's first and last name and identification number is on each page of record.
- All entries specify location, date, times of service provision and are legible.
- Services provided by the PCP.
- Identification of the type of service being provided.

- All entries are initialed or signed by the author including professional credentials, if any.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations and illnesses.
- Allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
- Information regarding personal habits such as smoking and history of alcohol use and substance use (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each Member.
- Patient’s chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- Referrals for therapeutic services.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect those long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Specific interventions, including name, dosage, and route of medications administered.
- Any supplies dispensed as part of the service.
- Health care education provided to patients, family Members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan’s Preventive Health Guidelines.
- Member’s response to staff interventions.
- An immunization record is up to date (for Members 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.

- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other Providers.
- Identification of the timeframe for documentation completion.
- Process to ensure units of service billed for payment are based on services provided with substantiating documentation.
- A Provider may correct a medical record before submitting a claim for reimbursement; however, the correction must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

Medical Record Audits and Requests

The Plan conducts medical record reviews to capture HEDIS® data not obtained through claims submission, and for other reasons. Medical records may be audited year-round. This effort is part of health plan operations and within plan expectations for Participating Providers. Record requests will be made in writing, with at least five business days' advance notice for records requested for on-site audits.

The QM Department will conduct random quality reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality reviews will be forwarded to the certifying or accrediting entity.

A quality review could include, but is not limited to, interviews with the Member and the Member's parents or legal guardian, designated case manager, and/or Provider staff. A review of case files, staff personnel records, compliance with Provider standards with state and federal code, and organizational policies and procedures and documentation.